MENTAL HYGIENE

VOL. I OCTOBER, 1917 No. 4

THE CARE AND TREATMENT OF MENTAL DISEASES AND WAR NEUROSES ("SHELL SHOCK") IN THE BRITISH ARMY*

THOMAS W. SALMON, M.D.

Major, Medical Officers' Reserve Corps, U. S. Army; Medical Director, National Committee for Mental Hygiene

INTRODUCTION

NO medico-military problems of the war are more striking than those growing out of the extraordinary incidence of mental and functional nervous diseases ("shell shock"). Together these disorders are responsible for not less than one seventh of all discharges for disability from the British Army, or one third if discharges for wounds are excluded. A medical service newly confronted like ours with the task of caring for the sick and wounded of a large army cannot ignore such important causes of invalidism. By their very nature, moreover, these diseases endanger the morale and discipline of troops in a special way and require attention for purely military reasons. In order that as many men as possible may be returned to the colors or sent into civil life free from disabilities which will incapacitate them for work and self-support, it is highly desirable to make use of all available information as to the nature of these diseases among soldiers in the armies of our

*This article consists of sections of Dr. Salmon's report on his recent visit to England together with an appendix entitled "Facilities Needed for Efficient Treatment of Mental Diseases in a Modern Public Institution." For lack of space, the section, "Mental Diseases (Insanity)," and the appendices, "References in English to Mental Diseases and War Neuroses ('Shell Shock') and Their Treatment and Management," and "Special Military Hospitals for Mental Diseases and War Neuroses ('Shell Shock') in Great Britain and Ireland," are omitted. The full report will be published as a monograph, copies of which may be obtained from The National Committee for Mental Hygiene. The appendix entitled, "The Use of the Institutions for the Insane as Military Hospitals," was published in the July number of MENTAL HYGIENE.

allies and as to their treatment at the front, at the bases and at the centers established in home territory for their "reconstruction."

England has had three years' experience in dealing with the medical problems of war. During that time opinion has matured as to the nature, causes and treatment of the psychoses and neuroses which prevail so extensively among troops. A sufficient number of different methods of military management have been tried to make it possible to judge of their relative merits. My visit to England was for the purpose of observing these matters at first hand so that I might contribute information which might aid in formulating plans for dealing with mental and nervous diseases among our own forces when they are exposed to the terrific stress of modern war.

Acknowledgments

I wish, at the outset, to record my appreciation of the many courtesies which enabled me to use the limited time at my disposal to the best advantage. The Army Council, upon the request of Ambassador Page, agreed to place at my disposal every facility for studying mental and nervous diseases. The medical officers of the special hospitals for mental and nervous cases, through the courtesy of Sir Alfred Keogh, Director General of the Royal Army Medical Corps, gave me opportunities to observe the work of the institutions under their charge. Others actively engaged in dealing with various administrative and clinical phases of these problems not only gave me valuable information but very kindly offered suggestions as to practical means by which our army might profit by the experience of British medical officers. I would mention especially Lt. Colonel William Aldren Turner, the principal advisor to the government in these matters; Lt. Colonel Sir John Collie, President of the Special Pension Board on Neurasthenics; Sir William Osler, under whose direction work is carried on in the special hospital for functional disorders of the heart; Dr. C. Herbert Bond of the Board of Control; Dr. Henry Head, who represented the Medical Research Committee in the conference upon nervous diseases among soldiers, held in Paris in April, 1916; Dr. H. Crichton Brown who has prepared a thoughtful memorandum on the subject for the War Office; Lt. Colonel Sir Robert Armstrong-Jones and the American liaison officers in London—Brigadier General Bradley and Lt. Colonel Lyster of the army and Surgeon Pleadwell of the navy. Dr. William Morley Fletcher, Secretary of the Medical Research Committee, which from an early period in the war has directed attention to the importance of nervous diseases, presented me with a motion picture film showing some of the more common symptoms in soldiers suffering from the neuroses. Dr. John T. MacCurdy, Associate in Psychiatry at the New York State Psychiatric Institute, who was studying the war neuroses in special hospitals in London, very kindly visited the Moss Side Military Hospital at Maghull and the Craiglockhart Hospital for

officers, near Edinboro, and furnished me with reports on the facilities for treatment at these institutions.

It is impossible to examine closely any phase of the work of caring for disabled soldiers in Great Britain without being profoundly impressed with the high degree of executive and scientific skill with which the unprecedented medical problems of the war have been met. More than twice as many hospital beds have been provided for soldiers and sailors as existed in the whole United Kingdom in August, 1914, for the civil population. In the stress of war, with all difficulties immensely increased, special types of treatment have been provided which the most enlightened civil communities had not yet been able to supply in time of peace. These almost incredible achievements were made possible by the patriotic efforts with which the nation disposed of obstacles in every direction. Beneath all this work is the deep sympathy which officials and the public alike bestow upon all those returning from the front who are in need of care or attention.

Scope of Report

I have omitted entirely from this report any account of the treatment of organic nervous diseases and of injuries to the central nervous system or the peripheral nerves. Organic nervous diseases are not especially frequent and seem to present no special military problems. Injuries of the central nervous system are frequent and severe. Those that do not prove fatal very quickly are well cared for at first in general surgical wards where the services of neurologists and neurological surgeons are available and later in special hospitals or special hospital wards. A very serious difficulty in dealing with destructive brain and cord lesions is that the patients sooner or later pass from hospitals in which special care and nursing are provided to their homes or to poorly equipped auxiliary hospitals in which many soon get worse or die. Injuries to the peripheral nerves are frequent and important, in fact there are few extensive injuries to the extremities in which important nerves escape. With neurological advice, the surgeons deal with these cases successfully in the base hospitals and their after-treatment is well carried on in the "reconstruction centers" for orthopedic cases. Neither of these classes of injuries concerns us especially in a consideration of the treatment and military management of mental and functional nervous diseases, except for the fact (to be commented upon later) that the treatment of the war neuroses might be carried out advantageously in home territory in co-operation with orthopedic reconstruction centers.

Although the problems presented by mental and functional nervous diseases have many clinical and administrative features in common and although these disorders should be dealt with by medical officers with the

same kind of special training, it seems desirable to consider their treatment in England separately in this report.

My observations as to the nature of the neuroses met with in war are based partly upon a study of the very extensive literature upon this subject which has come into existence since the commencement of the war, but chiefly upon personal conversation with medical men engaged in treating these cases in England. It is almost needless to say that during a short period spent largely in securing information regarding facilities for treatment and administrative methods of management and in examining special hospitals for the care of these cases, I had no opportunity to make original clinical observations, although I saw and examined superficially many cases of all degrees of severity.

WAR NEUROSES ("SHELL SHOCK")

Although an excessive incidence of mental diseases has been noted in all recent wars, it is only in the present one that functional nervous diseases have constituted a major medico-military problem. As every nation and race engaged is suffering severely from these disorders, it is apparent that new conditions of warfare are chiefly responsible for their prevalence. None of these new conditions is more terrible than the sustained shell fire with high explosives which has characterized most of the fighting. It is not surprising, therefore, that the term "shell shock" should have come into general use to designate this group of disorders. The vivid, terse name quickly became popular and now it is applied to practically any nervous symptoms in soldiers exposed to shell fire that cannot be explained by some obvious physical injury. It is used so very loosely that it is applied not only to all functional nervous diseases but to well-known forms of mental disease, even general paresis. Such a situation is most unsatisfactory and at the present time an attempt is being made to improve the nomenclature of the nervous disorders of war.

Discussion of clinical features of the war neuroses is not within the scope of this report, which deals with treatment and military management.* It is impossible, however, even to define the

*These extraordinarily interesting medical problems of the war are dealt with in a rapidly expanding volume of special literature. The July number of MENTAL HYGIENE (Vol. I, No. 3) contains a résumé of this literature. One hundred and forty-one references in English are given in an appendix of this report. (See footnote, page 509.) Attention is directed particularly to the contributions of Major Frederick M. Mott, Professor G. Elliot Smith, Captain CharlesS. Myers, Captain Clarence B. Farrar, Captain M. D. Eder and also to the extensive report by Dr. John T. MacCurdy in the *Psychiatric Bulletin* (N. Y.) for July, 1917.

problem with which we are dealing without a few general observations on the nature of the disorders which are grouped under the name "shell shock".

The subject can be clarified a little by dividing the different conditions so designated into some clinical and etiological groups. First should be considered cases in which the patients have been actually exposed to the effects of high explosives.

1. Not infrequently, just how often it is impossible to say, exploding shells or mines cause death without external signs of injury. Apparently death in these cases is sometimes due to damage to the central nervous system.

2. In another group of cases severe neurological symptoms follow burial or concussion by explosions in characteristic syndromes suggesting the operation of mechanical factors. The studies of Major Mott indicate that concussion, aerial compression and the rapid decompression following it, "gassing" from the drift gases (carbon monoxide and oxides of nitrogen) generated by the explosion and other purely mechanical effects of shell explosion may result in transitory or permanent neurological symptoms of a type unfamiliar in the neuroses.

There can be no question of the propriety of supplying the term "shell shock" to these two groups of cases if a specific term is required.

3. Another group of cases, among those exposed to shell fire, includes patients in whom, while there may or may not be damage to the central nervous system, the symptoms are those of neuroses familiar in civil practice even though colored in a very distinctive way by the precipitating cause. In this group of cases, in which there is possibility but no proof of damage to the central nervous system, the symptoms present which might be attributable to such damage are quite overshadowed by those characteristic of the neuroses.

It is about these cases that much controversy exists. Mott includes them in his group of "injuries of the central nervous system without visible injury," holding that a physical or a chemical change at present unknown to us must underlie such striking disabilities. Others give less weight to the factor of physical damage and yet recognize its existence and reconcile the wide range of neurotic symptoms with the very minute amount of damage which may exist by terming these cases "traumatic neuroses." Others again feel that psychogenetic factors determine not only the continuing neurosis but even the initial unconsciousness and special sense disturbances.

4. There is a group of cases in which even the slightest damage to the central nervous system from the direct effects of explosions is exceedingly improbable, the patients being exposed only to conditions to which hundreds of their com-

rades who develop no symptoms are exposed. In these cases the symptoms, course and outcome correspond with those of the neuroses in civil practice.

If all neuroses among soldiers were included in these groups the use of the term "shell shock" might be defended. But many hundreds of soldiers who have not been exposed to battle conditions at all develop symptoms almost identical with those in men whose nervous disorders are attributed to shell fire. The non-expeditionary forces supply a considerable proportion of these cases.

To state that, in the cases included in the last two groups of cases in which shell explosions play a part, the mechanism is that of a neurosis by no means excludes the operation of physical causes. Very little is known, however, regarding the physiological basis of the disorders in this group or even in those in the first two groups in which the issues are apparently predominantly organic. It may be that in the latter two groups endocrinitic disturbances are important. Minute injuries of the cord may exist and factors such as exposure, exhaustion, vascular disequilibrium and disorders of metabolism may enter into their causation. Treatment directed along the lines suggested by such an etiology has thus far proved quite ineffective, however, and there is only the most slender basis of experimental work to show that such factors are important. This is a fertile field for research. It is earnestly hoped by all those consulted in England that the United States Army, coming freshly into contact with this problem, will organize a working party of psychiatrists, neurologists, neuro-pathologists and internists and try to clear some of these issues.

It is the opinion of most psychiatrists and neurologists who have been studying and treating "shell shock" in the British Army that the fourth group is the largest and most important and that, whatever the unknown physiological basis, psychological factors are too obvious and too important in these cases to be ignored. In support of this view there is much evidence, some of which it may be worth while to give.

1. The striking excess of war neuroses among officers. The ratio of officers to men at the front is approximately 1:30. Among the wounded it is 1:24.* *Among the patients admitted to the special hospitals for war neuroses in England during the year ending April 30, 1917, it was 1:6.*

2. The rarity of war neuroses among prisoners exposed to mechanical shock.

*Analysis of 381,983 casualties between August 4, 1914 and August 21, 1915, reported in a statement in Parliament, and 901,534 casualties between July, 1916 and July, 1917.

3. The rarity of war neuroses among the wounded exposed to mechanical shock.

4. The clinical resemblance which the war neuroses bear to the neuroses of civil life in which the element of mechanical shock is lacking while the psychological situations are somewhat alike.

5. The fact that severe war injuries to the brain and spinal cord are not accompanied by symptoms similar to those in "shell shock," in which injuries of less degree are assumed.

6. The success attending therapeutic measures employed with reference to the psychological situations discovered in individual cases.

These suggestive facts require some elaboration. The high prevalence of "shell shock" among officers corresponds with the distribution of the neuroses, with reference to education and social grouping, in civil life. Soldiers who are wounded and those who are taken prisoners in battle are exposed to wind concussion and rapid decompression and other mechanical factors in the same degree as their comrades who suffer from neuroses. One must conclude from the fact that they escape that being wounded or being captured provides them with something which the neurosis provides for others. The symptoms exhibited usually bear a more direct relation to the existing psychological situation than they could possibly bear to the localization of a neurological injury. Thus a soldier who bayonets an enemy in the face develops an hysterical tic of his own facial muscles; abdominal contractures occur in men who have bayonetted enemies in the abdomen; hysterical blindness follows particularly horrible sights; hysterical deafness appears in those who find the cries of the wounded unbearable and men detailed to burial parties develop anosmia.

The psychological basis of the war neuroses (like that of the neuroses in civil life) is an elaboration, with endless variations, of one central theme: escape from an intolerable situation in real life to one made tolerable by the neurosis. The conditions which may make intolerable the situation in which a soldier finds himself hardly need stating. Not only fear, which exists at some time in nearly all soldiers and in many is constantly present, but horror, revulsion against the ghastly duties which must be sometimes performed, intense longing for home, particularly in married men, emotional situations resulting from the interplay of personal conflicts and military conditions, all play their part in making an escape of some sort mandatory. Death provides a means which cannot be sought consciously. Flight or desertion is rendered impossible by ideals of duty, patriotism, and honor, by

the reactions acquired by training or imposed by discipline and by herd reactions. Malingering is a military crime and is not at the disposal of those governed by higher ethical conceptions. Nevertheless, the conflict between a simple and direct expression in flight of the instinct of self-preservation and such factors demands some sort of compromise. Wounds solve the problem most happily for many men and the mild exhilaration so often seen among the wounded has a sound psychological basis. Others with a sufficient adaptability find a means of adjustment. The neurosis provides a means of escape so convenient that the real source of wonder is not that it should play such an important part in military life but that so many men should find a satisfactory adjustment without its intervention. The constitutionally neurotic, having most readily at their disposal the mechanism of functional nervous diseases, employ it most frequently. They constitute, therefore, a large proportion of all cases but a very striking fact in the present war is the number of men of apparently normal mental make-up who develop war neuroses in the face of the unprecedentedly terrible conditions to which they are exposed.

One of the chief objections to the use of the term "shell shock" is the implication it conveys of a cause acting instantly. The train of causes which leads to the neurosis that an explosion ushers in is often long and complicated. Apparently in many military cases mental conflicts in the personal life of the soldier that are not directly connected with military situations influence the onset of the neuroses. Thus men who have been doing very well in adapting themselves to war develop "shell shock" immediately after receiving word that their wives have gone away with other men during their absence.

Approached from the psychological viewpoint, the symptoms in the war neuroses lose much of their weird and inexplicable character. Most of them can be summed up in the statement that the soldier loses a function that either is necessary to continued military service or prevents his successful adaptation to war. The symptoms are found in widely separated fields. Disturbances of psychic functions include delirium, confusion, amnesia, hallucinations, terrifying battle dreams, anxiety states. The disturbances of involuntary functions include functional heart disorders, low blood pressure, vomiting and diarrhea, enuresis, retention or polyuria, dyspnoea, sweating. Disturbances of voluntary muscu-

lar functions include paralyses, tics, tremors, gait disturbances, contractures and convulsive movements. Special senses may be affected producing pains and anesthesias, mutism, deafness, hyperacusis, blindness and disorders of speech. It is highly significant that, in this unprecedented prevalence of functional nervous diseases among soldiers, no symptoms unfamiliar to those who see the neuroses in civil life present themselves.

In all of these the soldier is afflicted with more or less incapacity without obvious expansion. This is a condition involving grave dangers. His condition is degrading and is often rendered more so by the punishment or ridicule to which he is subjected. For this reason, immediately after the onset of the symptoms of the neurosis, the patient passes through a very critical period. Improper management may add to the primary neurological disability—which is largely beyond our power of preventing—secondary effects which go even further in producing nervous invalidism. Long-continued treatment in general hospitals, confusion of the neurosis present with the organic nervous diseases, and unintelligent management, all tend to produce the chronic "shell shock" cases which are so familiar in the special hospitals for these disorders. Symptoms which were at one time quite easily removable become fixed and refractory or new ones are constantly produced. The mental attitude—the patient's morale as a soldier and his attitude toward his disorder—reaches a very low level, will is seriously impaired and a chronic invalid replaces a temporarily incapacitated soldier. These are matters in the realm of clinical psychiatry and psycho-pathology and are outside the scope of this report. Space is given to them here only because of their very important bearing upon treatment and military management.

Prevalence

The medical statistics of the war are as yet untabulated. Even if the records contained the information desired it would be very difficult to state the prevalence of the neuroses on account of the defective nomenclature employed. It is doubtful if there is another group of diseases in which more confusion in terms exists. Nervous or mental symptoms coming to attention after the soldier has been exposed to severe shell fire, are almost certain to be diagnosed as "shell shock," and yet when such patients are received in England, well-defined cases of general paresis, epilepsy

or dementia praecox are often found among them. This source of confusion tends to swell the number of cases reported under the term "shell shock," but there are many other sources of error which tend to diminish the apparent prevalence of the war neuroses. Chief among these is reporting the neuroses under the name of the most prominent somatic symptom. The largest group of cases in which this is done is made up of patients diagnosed officially as having disordered action of the heart ("D. A. H."). Where the only symptoms are cardio-vascular ones of neurotic origin, a legitimate question of medical nomenclature exists, but one sees in the wards or hospitals given over to functional heart disorders, patients with hysterical paralyses, tics, tremors, mutism, anxiety states and other severe neurotic symptoms. Another source of error is the practice, made mandatory by a recent order, of returning these cases (when occurring in soldiers engaged in actual fighting) as "injuries received in action."

With a view to discovering the prevalence of the neuroses and insanity, Sir John Collie, President of the Special Pension Board on Neurasthenics, made an analysis of 10,000 discharge certificates for disability, interpreting the diagnoses given in the light of his very large experience. He found that of these 10,000 consecutive cases, the neuroses constituted 20 per cent.

The number of cases treated in the special hospitals in England gives some idea of the prevalence of these disorders, but the fact that the number of troops in the expeditionary and the non-expeditionary forces is confidential, makes it impossible to give the rates for the two great divisions of the British Army. During the year ending April 30, 1916, approximately 1,300 officers and 10,000 men were admitted to the special hospitals for "shell shock" and neurasthenics in Great Britain. The 1,800 beds in these special hospitals constitute less than half the total provisions in Great Britain for such cases, as neurological departments exist in the large territorial general hospitals and in the Royal Victoria Hospital in Edinboro. Moreover, a constantly increasing number of these cases are being treated in France. The recoveries in the hospitals there diminish, to an unknown degree, the number of cases received in the hospitals in Great Britain. It is the belief of those who have made an effort to ascertain the prevalence of the war neuroses, that the rate among the expeditionary forces is not less than ten per thousand annually, and among the home forces not less than three per thousand.

Treatment

General arrangements. When soldiers suffering from functional nervous disorders began to arrive in England from the expeditionary forces in September, 1914, no special civil or military hospitals existed for their reception. In the case of mental diseases it was an easy task to convert "D Block" at the Royal Victoria Hospital into a clearing hospital and to utilize civil institutions for the insane for continued care, but in England, as in the United States, there are no public civil hospitals that are engaged exclusively in the work of treating the neuroses. The special civil hospitals for organic nervous diseases were soon filled with patients suffering from severe neurological injuries and were able to do very little on behalf of those with functional nervous disorders.

For a short time it was necessary to care for all such cases in general military hospitals for medical and surgical conditions. The rapid increase in the number of such cases during October and November, 1914, led to the detail of a special medical officer to ascertain their special needs and to prepare a plan for meeting them. The recommendations of this officer that special institutions be provided for functional nervous diseases was approved and when, in December, 1914, the Moss Side State Institution at Maghull was turned over to the War Office, the first military hospital for functional nervous diseases was available. This institution was particularly suitable for this purpose. It had been completed but not opened for the care of mental defectives of the delinquent type and consisted of detached villas accommodating 347 patients. The number of these patients was so great, however, that general hospitals were still called upon to deal with them. The establishment of neurological departments in these hospitals partly met the situation until additional special hospitals could be provided. The second such hospital was secured by using a detached portion of Middlesex County Asylum in London. This hospital, accommodating 278 additional patients, was renamed the Springfield War Hospital. The foresight of Sir Alfred Keogh and his advisors thus enabled England to make provision for these cases in special military hospitals at an early period in the war.

With more than one hospital available, it was possible to make different provisions for different classes of patients suffering from

war neuroses. A clearing hospital was therefore established early in 1915 at the Fourth London Territorial General Hospital where the best disposition could be determined. The Maudsley Hospital, a psychopathic hospital for the County of London, was nearing completion at this time and, as it adjoined the Kings College Hospital which formed the larger part of the Fourth London Hospital, it was utilized as a nucleus for this clearing station. The Maudsley Hospital accommodates 175 men and 20 officers; the neurological section—"the Maudsley extension"—accommodates 450 men and 80 officers. Thus by the spring of 1915, England was provided with a clearing hospital for war neuroses and two special institutions for their continued care. Notwithstanding this provision, by far the greater number of cases were cared for in general hospitals in England and no special provision for continued treatment existed in France. The disadvantages of attempting to treat functional nervous disorders in general hospitals were very apparent and so neurological sections were established in territorial general hospitals in England, Scotland and Wales and in the Royal Victoria Hospital at Netley. Other special hospitals have been provided since, a directory and descriptions of those visited being given in Appendix III.*

When the submarines commenced to sink hospital ships indiscriminately last year a great deal of the medical work previously done in England was undertaken in France and so special provisions for functional nervous cases were made at Havre, Ireport, Boulogne, Rouen and Étaples. Formerly little more than establishing the diagnosis was done in France. It is likely that the work of caring for these cases will be turned over more and more to the special hospitals in France as the results of treatment there have been, on the whole, so much more successful than in home territory.

A recent extension of treatment is that of providing care still nearer the front. The striking results obtained in Casualty Clearing Stations and similar advanced posts in the French Sanitary Service (*postes de chirurgie d'urgence*) are confirmed by many observers.

Capt. William Brown, a psychiatrist, who has recently had the opportunity of working in a Casualty Clearing Station of the British Expeditionary Forces,

*An interesting account of the arrangements for the care of soldiers with war neuroses is given in a special article by Lt. Col. William Aldren Turner (*Lancet*, London, May 27, 1916, pp. 1073–1075).

reports that of 200 nervous and mental cases which passed through his hands in December, 1916, 34 per cent were evacuated to the base after seven days' treatment and 66 per cent returned to duty on the firing line after the same average period of treatment. Four of these cases reappeared at the same Casualty Clearing Station.

Capt. Louis Casamajor of the U. S. Army, neurologist to Base Hospital No. 1, British Expeditionary Force, says in a recent letter: "It is a mistake to send these cases to England. We need an intermediate step between the general hospital and the convalescent camp. Of course they never should get into general hospitals at all but should be sent from Casualty Clearing Stations direct to neuro-psychiatric hospitals. . . . I hope our army will have a psychiatrist in each Casualty Clearing Station to weed these cases out and send them to their proper places and not have them knock around from one general hospital to another, being pampered into hard-set neuroses."

Lèri, working in the neuro-psychiatric center of the second French Army, reports that 91 per cent of the cases received from July to October, 1916, were returned to the fighting line. Marie reports that the neuroses are less frequently met with in Paris now that they are treated immediately upon their appearance in the Army neuro-psychiatric centers.*

Major Frederick W. Mott says: "I regard this matter of preventing the fixation of a functional paralysis as of supreme importance both in respect to the welfare of the individual and from the economic point of view of the state."

Roussy and Boisseau,† describing the work of an army neuro-psychiatric center say: "The results obtained after six months show that a neuro-psychiatric center can render incontestable services to an army both from a medical and a military point of view. For functional nervous cases it avoids sojourns (more dangerous the more they are prolonged) in the hospitals at the rear where these patients are generally lost. It allows of the treatment of other nervous or mental cases that are quickly curable and the direct evacuation to the special centers in the interior of those more seriously affected."

Captain C. B. Farrar‡ says: "Moreover it seems to be a fact that treatment is more satisfactorily carried out and cures more speedily accomplished in hospitals close to the front and where the spirit of army discipline is most felt. It is conceded that the worst possible place to treat a case of war neurosis is in his home town, where in so far especially as the more striking objective symptoms are concerned, the sympathetic wonderment and commiseration of friends create a positive demand which the ideogenic factor of the patient's illness continues faithfully to supply. In hospitals close behind the lines there is still the atmosphere of the front and a mental tone which comes from mass-suggestion of men striving shoulder to shoulder. This mental tone is eminently supportive and therapeutic, but with the transfer of patients to interior hospitals far behind the lines it naturally gives way. The circumstances which produce it are no longer operative and the nervous relaxation and reaction which ensue are often conspicuously and painfully evident. Out of danger, far from the front, perhaps among hero-worshipping friends, the invalid is unavoidably conscious of himself more

*Revue neurologique (Nov.–Dec., 1916).

†Paris médicale, 1: 14–20 (Jan. 1, 1916).

‡American journal of insanity, 73: 711–712 (April, 1917).

as an individual and less as a link in the battle line. All the conditions are favorable for the fixation and reinforcement of the neurosis as an ideogenic process. Too often he is found to be the victim not only of his malady, but of his friends as well, and in more senses than one."

General principles. Methods of treatment employed in different special hospitals are described in Appendix III. With so much regarding the war neuroses the subject of controversy, it is not surprising that different methods of treatment have come into existence. The Royal Army Medical Corps has seen fit to leave these matters largely to the specialists in charge of the different hospitals and so the treatment in each reflects, to a certain degree, the conception of the nature of war neuroses held by the medical officer in charge. Certain general principles regarding treatment may be stated.

The experience of the British "shell shock" hospitals emphasizes the fact that the treatment of the war neuroses is essentially a problem in psychological medicine. While patients with severe symptoms of long duration recover in the hands of physicians who see but dimly the mechanism of their disease and are unaware of the means by which recovery actually takes place, no credit belongs to the physician in such cases and but little to the type of environment provided. In the great majority of instances the completeness, promptness and durability of recovery depend upon the insight shown by the medical officers under whose charge the soldiers come and their resourcefulness and skill in applying treatment.

The first step in treatment is a careful study of the individual case. There are no specific formulae for the cure of mutism, paralyses or tremors or other manifestations of war neuroses. These are symptoms and the patient must be treated as well as his symptoms. As in all other psychiatric work, efforts must first be made to gain an understanding of the personality—the fabric of the individual in whom the neurosis has developed. His resources and limitations in mental adaptation will determine in a large measure, the specific line of management. The military situation is most striking but the problem which life in general presents to the individual and the type of adaptation which he has found serviceable in other emergencies are of as much importance as the specific causes for failure in the existing situation. The disorder must be looked at as a whole. The incident which seems to have precipitated the neurosis—whether

shell explosion, burial or disciplinary crisis—must receive close attention but not to the exclusion of other factors less dramatic but often more potent in the production of the neurosis. It has often been said that some of the symptoms of hysteria are the work of the physician and are created—not disclosed—by neurological examinations. This is apparently true, but the question whether analgesia can exist until the pin prick demonstrates it is somewhat like the question whether sound can exist without an ear to receive it. It is not only true, but a fact of great practical importance, that a skilful, searching, psychological examination often constitutes the first step in actual treatment.

In the analysis of the situation, as well as in the subsequent management of the patient, the medical officer's attitude is of much importance. He must be immune to surprise or chagrin. Although understanding sympathy is nearly as useful as misdirected sympathy is harmful, he must always remain in firm control.

The resources at the disposal of the physician in treating the war neuroses are varied. The patient must be re-educated in will, thought, feeling and function. Persuasion, a powerful resource, may be employed, directly backed by knowledge on the part of the patient as well as the physician of the mechanism of the particular disorder present. Indirectly, it must pervade the atmosphere of the special ward or hospital for "shell shock". Hypnotism is valuable as an adjunct to persuasion and as a means of convincing the patient that no organic disease or injury is responsible for his loss of function. Thus in mutism the patient speaks under hypnosis or through hypnotic suggestion and thereafter must admit the integrity of his organs of speech. The striking results of hypnotism in the removal of symptoms are somewhat offset by the fact that the most suggestible who yield to it most readily are particularly likely to be the constitutionally neurotic. A mental mechanism similar to that which produced the disorder is being used in such cases to bring about a cure.

Recovery within the sound of artillery or at least "somewhere in France" is more prompt and durable than that which takes place in England. For severe cases and those which through mismanagement have developed the unfortunate secondary symptoms of "shell shock" and in whom long-continued treatment is necessary, a rural place is best.

Re-education by physical means is a valuable adjunct to treatment in recent cases but particularly in chronic cases who have been mismanaged and in those who are recovering from long continued paralyses, tics, mutism and gait disorders. While drills and physical exercises have their specific uses, occupation is the best means. Non-productive occupations should be avoided.

Occupations are conveniently classified as:

1. Bed.
2. Indoor.
3. Outdoor.

1. Basket-making and net-making are good bed occupations for cases with extensive paralyses, as are making surgical dressings and various minor finishing operations (sandpapering, polishing, etc.) on products of the shops. All occupations, and especially those which are carried on by patients seriously incapacitated, should be regarded as only steps in a process of progressive education. Every effort must be made to prevent skill acquired in them from being considered as a substitute for full functional activity. Herein is an important difference between the "re-education" of neurotic and orthopedic cases. In the latter the purpose is often to make the remaining sound limb take on the functions of one which is missing or permanently disabled. *The function held in abeyance through neurotic symptoms must never be looked upon as lost.* It can and must be restored and if another function is developed as its surrogate the day of full recovery is thereby postponed. Bed occupations, therefore, must always be regarded as the first steps in a series which is to culminate in full activity. Progress through achievements constantly more difficult is the keynote of re-education in the war neuroses.

2. A wide variety of indoor occupations should be provided including at the minimum carpentry, wood carving, metal work and cement work. Printing, bookbinding, cigarette making, electric wiring and other work should be added as opportunities permit.

3. Farming, gardening and building operations are desirable outdoor occupations. Where possible, wood sawing and chopping are very desirable as is the care of stock not requiring much land (squabs, guinea pigs, rabbits, game, frogs).

Before even the simplest occupation can be engaged in it is sometimes necessary to re-educate paraplegics and ataxics in walking and co-ordination. Just as soon as possible, exercises should be replaced by productive occupations which will accom-

plish the same results more quickly and more satisfactorily. The same is true of gymnastic exercises which in the early steps of treatment constitute a valuable resource but which should be replaced by specially devised, useful tasks. Swimming has a unique place in the treatment of gait disturbances, paralyses and tics. One of the first pieces of construction undertaken by the outdoor patients at a reconstruction center should be that of building a large concrete swimming tank.

Hydrotherapy and electrotherapy have a distinct value when they are applied with absolute sincerity and full realization on the part of patient and medical officer of the rôle which they actually play in the treatment of functional nervous diseases.

The experience in English hospitals has demonstrated the great danger of aimless lounging, too many entertainments and relaxing recreations such as frequent motor rides, etc. It must be remembered that "shell shock" cases suffer from a disorder of will as well as function and it is impossible to effect a cure if attention is directed to one at the expense of the other. As Dr. H. Crichton Miller has put it, "'shell shock' produces a condition which is essentially childish and infantile in its nature. Rest in bed and simple encouragement is not enough to educate a child. Progressive daily achievement is the only way whereby manhood and self-respect can be regained."

Outcome

It was impossible for me to discover the end-results of treatment. The following table shows the disposal of 731 discharges from the Red Cross Military Hospital at Maghull during the year ending June 30, 1917.

	Number	*Per cent*
To military duty	153	20.9
To civil life	476	65.1
To other hospitals	88	12.0
To civil institutions for the insane	7	1.0
Died	3	0.4
Deserted	4	0.6
	731	100.0

It is the opinion of the commanding officer of this hospital that few men (with the severe or chronic types of neuroses there received) can be sent back to military duty at the front. More

could be returned to duty at the base but for the fact that after having been in a "shell shock hospital," they are regarded as being poor material and little effort is taken to train them for their new duties. Under such conditions the men become discouraged and soon show signs of relapse. Those discharged to civil life have done satisfactorily—as might be expected when one bears in mind the genesis of the neuroses in war.

At the Granville Canadian Special Hospital at Ramsgate, upwards of 60 per cent of the patients admitted were returned to the front. The experience of this hospital is of special value to us because the cases treated are those which seem likely to recover within six months. All others and those who do not improve quickly at Ramsgate are sent to Canada. It would be wise for the United States Army to adopt a similar policy.

In the special wards established in France the recoveries are still more numerous.*

It is evident that the outcome in the war neuroses is good from a medical point of view and poor from a military point of view. It is the opinion of all those consulted that, with the end of the war, most cases, even the most severe, will speedily recover, those who do not being the constitutionally neurotic and patients who have been so badly managed that very unfavorable habit-reactions have developed. This cheering fact brings little consolation however, to those who are chiefly concerned with the wastage of fighting men. The lesson to be learned from the British results seems clear—that treatment by medical officers with special training in psychiatry should be made available just as near the front as military exigency will permit and that patients who cannot be reached at this point should be treated in special hospitals in France until it is apparent that they cannot be returned to the firing lines. *As soon as this fact is established military needs and humanitarian ends coincide.* Patients should then be sent home as soon as possible. The military commander may have the satisfaction of knowing that food need not be brought across to feed a soldier who can render no useful military service, and the medical officer may feel that his patient will have what he most needs for his recovery—home and safety and an environment in which he can readjust.

Looking at the matter from a military point of view alone, one might ask whether it is not desirable to send home all "shell

*Pp. 520, 521.

shock" cases—in whom so much effort results in so few recoveries. Such a decision would be as unfortunate from a military as from a humanitarian standpoint. Its immediate effect would be to increase enormously the prevalence of the war neuroses. In the unending conflict between duty, honor and discipline, on the one hand, and homesickness, horror, and the urgings of the instinct of self-preservation on the other, the neurosis—as a way out—is already accessible enough in most men without calling attention to it and enhancing its value by the adoption of such an administrative policy.

Medico-legal Relations

The sudden appearance of marked incapacity, without signs of injury, in a group of men to whom invalidism means a sudden transition from extreme danger and hardship to safety and comfort, quite naturally gives rise to the suspicion of malingering. The general knowledge among troops of the more common symptoms of "shell shock" and of the fact that thousands of their comrades suffering from it have been discharged from the army suggests its simulation to men who are planning an easy exit from military service by feigning disease. It is therefore of much military importance that medical officers be not deceived by such frauds. On the other hand, especially before the clinical characters and remarkable prevalence of war neuroses among soldiers had become familiar facts, not a few soldiers suffering from these disorders were executed by firing squads as malingerers. Instances are also known where hysterics have committed suicide after having been falsely accused of malingering. Mistakes of this kind are especially likely to occur when the patients have not been actually exposed to shell fire on account of the idea so firmly fixed in the minds of most line officers and some medical men that the war neuroses are always due to mechanical shock.

The diagnosis between neuroses and malingering may sometimes be extremely difficult but usually it is easy when the examiner is familiar with both conditions. The difficulties arise from the fact that in both, a disease or a symptom is simulated. As Bonnal says, "The hysteric is a malingerer who does not lie." The cardinal point of difference is that the *malingerer simulates a disease or a symptom which he has not in order to deceive others.* He does this consciously to attain, through fraud, a specific selfish end—usually safety in a hospital or discharge from the

military service. He lies and *knows* that he lies. *The hysteric deceives himself by a mechanism of which he is unaware and which is beyond his power consciously to control.* He is usually not aware of the precise purpose which his illness serves. This is shown by the fact that, in many cases, all that is necessary for recovery is to demonstrate clearly to the patient the mechanism by which this disability occurred and the unworthy end to which, unconsciously, it was directed.

There are a number of distinctive points of difference between hysteria and malingering, two of which it may be interesting to mention.

The malingerer, conscious of his fraudulent intent and fearful of its detection, dreads examinations. The hysteric invites examinations, as is well known to physicians in civil practice. When he has the opportunity he makes the rounds of clinics and physicians, especially delighting in examinations by noted specialists.

The hysteric, in addition to the symptoms of which he complains, often presents objective symptoms of which he is unaware. The malingerer, unless of low intelligence, confines his complaints to the disease or symptom which he has decided to simulate.

Malingering may follow or prolong a neurosis. This is not infrequently the case when mutism is succeeded by aphonia. In such cases the clinical picture presents changes very apparent to the experienced psychiatrist but it must be remembered that malingerers (like criminals in civil life) are often very neuropathic individuals.

The gravity of malingering as a military offense in an army in the field justifies the recommendation that no case in which the possibility of a neurosis or psychosis exists shall be finally dealt with until the subject is examined by a neurologist or psychiatrist. If neuro-psychiatric wards are provided in base hospitals in France as well as in the United States, such an examination will be feasible in practically all cases without causing undue delay. The knowledge that malingerers are subjected to expert examinations always tends to discourage soldiers from this practice.

RECOMMENDATIONS FOR THE UNITED STATES ARMY

The following recommendations for the treatment of mental diseases and war neuroses ("shell shock") in United States troops are based chiefly upon the experience of the British Army in dealing

with these disorders, as outlined in the foregoing report. The advice of British medical officers engaged in this special work has aided greatly in formulating the plans presented. At the same time conditions imposed by the necessity of conducting our military operations three thousand miles away from home territory have been borne in mind.

It seems desirable to consider separately in these recommendations, expeditionary and non-expeditionary forces. It is necessary to deal separately with mental and nervous diseases in the United States but not in France. While facilities existing at home can be utilized for the treatment of mental diseases it is necessary to create new ones for the treatment of the war neuroses. In France, where all facilities for treatment must be created by the medical department, the distinction between psychoses and neuroses need not be drawn so clo sely. Consequently, simpler and more effective methods of administrative management can be devised.

The importance of providing, in advance of their urgent need, adequate facilities for the treatment and management of nervous and mental disorders can hardly be overstated. The European countries at war had made practically no such preparations and they fell into difficulties from which they are now only commencing to extricate themselves. We can profit by their experience and, if we choose, have at our disposal, before we begin to sustain these types of casualties in very large numbers, a personnel of specially-trained medical officers, nurses and civilian assistants and an efficient mechanism for treating mental and nervous disorders in France, evacuating them to home territory and continuing their treatment, when necessary, in the United States.

Although it might be considered more appropriately under the heading of prevention than under that of treatment, the most important recommendation to be made is that of rigidly excluding insane, feebleminded, psychopathic and neuropathic individuals from the forces which are to be sent to France and exposed to the terrific stress of modern war. Not only the medical officers but the line officers interviewed in England emphasized, over and over again, the importance of not accepting mentally unstable recruits for military service at the front. If the period of training at the concentration camps is used for observation and examination, it is within our power to reduce very materially the difficult problem of caring for mental and nervous cases in France, in-

crease the military efficiency of the expeditionary forces and save the country millions of dollars in pensions. Sir William Osler, who has had a large experience in the selection of recruits for the British Army and has seen the disastrous results of carelessness in this respect, feels so strongly on the subject that he has recently made his views known in a letter to the *Journal of the American Medical Association** in which he mentions neuropathic make-up as one of the three great causes for the invariable rejection of recruits. In personal conversation he gave numerous illustrations of the burden which the acceptance of neurotic recruits had unnecessarily thrown upon an army struggling to surmount the difficult medical problems inseparable from the war.

It is most convenient to summarize the recommendations as follows and then to discuss each one somewhat in detail:

SUMMARY OF RECOMMENDATIONS FOR THE CARE AND TREATMENT OF MENTAL DISEASES AND WAR NEUROSES ("SHELL SHOCK") IN THE EXPEDITIONARY FORCES

OVERSEAS

1. *Base Section of Lines of Communication*
   (a) A Special Base Hospital of 500 beds for neuro-psychiatric cases, located at the base upon which each army (of 500,000–600,000) rests. These special base hospitals to be used for cases likely to recover and return to active duty within six months. Other cases to be cared for while waiting to be evacuated to the United States.
   (b) One or more Special Convalescent Camps in connection with (and conducted as part of) each Special Base Hospital.
2. *Advanced Section of Lines of Communication*
   (a) Special Neuro-Psychiatric Wards of 30 beds in charge of three psychiatrists and neurologists for each base hospital having an active service. These wards to be used for observation (including medico-legal cases) and for emergency treatment of mental and nervous cases.
   (b) Detail of a psychiatrist or neurologist attached to the neuro-psychiatric wards of base hospitals, to evacuation hospitals or stations further advanced as opportunities permit.

UNITED STATES

1. *Mental Diseases (insane)*
   (a) One or more Clearing Hospitals for reception, emergency treatment, classification and disposition of mental cases among enlisted men invalided home.
   (b) Clearing Wards (in connection with general hospitals for officers or private institutions for mental diseases) for reception, emergency treatment, classification and disposition of mental cases among officers invalided home.
   (c) Legislation permitting the Surgeon-General to make contracts with public and private hospitals maintaining satisfactory standards of treatment for the continued care of officers and men suffering from mental diseases until recommended for retirement or discharge (with or without pension) by a special board.

**Journal American medical association*, Vol. LXIX, No. 4, p. 290 (July 28, 1917).

(d) Appointment of a special board of three medical officers to visit all institutions in which insane officers and men are cared for under such contracts to see that adequate treatment is being given and to retire or discharge (with or without pension) those not likely to recover.

2. *War Neuroses ("shell shock")*

(a) Re-construction centers (the number and capacity to be determined by the need) for the treatment and re-education of such cases of war neuroses as are invalided home. Injuries to the brain, cord and peripheral nerves to be treated elsewhere.

(b) Special convalescent camps where recovered cases can go and not be subject to the harmful influences for those cases which exist in camps for ordinary medical and surgical cases.

(c) Employment of the Special Board of medical officers, recommended under "1 (d)," to visit all re-education centers and convalescent camps in which war neuroses are treated to see that adequate treatment is being given and to retire or discharge (with or without pension) those not likely to recover.

EXPEDITIONARY FORCES

I. OVERSEAS

The plan herein suggested for dealing with mental and functional nervous diseases in the expeditionary forces overseas presupposes that all sick and wounded soldiers who are not likely to be returned for duty in the fighting line within six months will be evacuated to home territory. The same considerations which led to the adoption of this policy by the Canadian Army are equally valid in the case of American troops. If large numbers of the sick and wounded who are not likely to return to active duty have to be cared for in France during long periods of disability, the amount of food and other supplies which must be sent overseas for them and for those who care for them will diminish the tonnage available for the transportation of munitions required for successful military operations; the great auxiliary hospital facilities available in the United States cannot be utilized and, in the case of the severe neuroses, fewer recoveries will take place. If submarine activities seriously interfere with the return of disabled soldiers to the United States and it is necessary to provide continued care, chronic cases should be evacuated to special hospitals established in France for this purpose. It is very desirable to maintain an active service in base hospitals that receive cases from the front. This is especially true in the case of the war neuroses.

(a) *Base Section of Lines of Communication.* The base upon which each army rests should be provided with a special base hospital of five hundred beds for neuro-psychiatric cases. Three years' experience in treating these cases in general hospitals in

England and France amply demonstrates the need for such an institution. Few more hopeful cases exist in the medical services of the countries at war than those suffering from the war neuroses grouped under the term "shell shock" *when treated in special hospitals by physicians and nurses familiar with the nature of functional nervous diseases and with their management.* On the other hand, the general military hospitals and convalescent camps presented no more pathetic picture than the mismanaged nervous and mental cases which crowded their wards before such special hospitals were established. Exposed to misdirected harshness or to equally misdirected sympathy, dealt with at one time as malingerers and at another as sufferers from incurable organic nervous disease, "passed on" from one hospital to another and finally discharged with pensions which cannot subsequently be diminished, their treatment has not been a wholly creditable chapter in military medicine. As one writer has said, "they enter the hospitals as 'shell shock' cases and come out as nervous wrecks." To their initial neurological disability (of a distinctly recoverable nature) are added such secondary effects as unfavorable habit-reactions, stereotypy and fixation of symptoms, the self-pity of the confirmed hysteric, the morbid timidity and anxiety of the neurasthenic and the despair of the hypochondriac. In such hospitals and convalescent homes inactivity and aimless lounging weaken will, and the attitude of permanent invalidism quickly replaces that of recovery. The provision of special facilities for the treatment of "shell shock" cases is imperative from the point of view of military efficiency as well as from that of common humanity, for more than half these cases can be returned to duty if they receive active treatment in special hospitals from an early period in their disease.

British experience indicates that about one hundred of the beds in each such special base hospital would be occupied by mental cases and the rest by those suffering from war neuroses. It is not necessary to make this division arbitrarily in advance, however, as both classes of cases can be cared for in the type of hospital to be proposed and re-distribution of patients can be made from time to time as circumstances require. It should be the object of these special base hospitals to provide treatment for all cases likely to recover and be returned to active duty within six months. Practically all mental cases, even those who recover during this period, as well as functional nervous cases presenting

an unfavorable outlook or which are unimproved by special treatment, should be evacuated to the United States as rapidly as transportation conditions will permit.

Each such hospital should be located with reference to its accessibility to other hospitals along the lines of communication of the army which it serves. This will necessitate its being on the main railway line down which disabled soldiers are evacuated from the front. It should also be within convenient reach of, although not necessarily at, the port of embarkation. If it is possible to secure a site in southern France where outdoor work can be continued during the winter many important advantages will be gained. Gardening and other outdoor occupations are so valuable that the amount of ground adjoining each base hospital, or contiguous to it, should be not less than one acre for every six patients of one third its population. Thus, at least thirty acres are required for a hospital with 500 beds.

The type of general hospital adopted by the American Army for cantonment camps could be used, with certain interior changes, but it would be more advantageous to secure a hotel or school and remodel it to perform the special functions of a hospital of this character. The living arrangements in these special hospitals are simpler than in general hospitals for medical and surgical cases. About five per cent of the bed-capacity will have to be in single rooms. This percentage will be somewhat greater in the psychiatric division and smaller in the neurological division. Less than three per cent of the population will be bed-patients. A sufficient number of rooms in both the neurological and psychiatrical divisions should be set aside for officers—the higher proportion of officers among patients with neuroses being taken into consideration in planning this department.

It is necessary to allow liberally for examining rooms, massage, hydrotherapy and electrotherapy and to provide one large room which can be used for an amusement hall. When the patients and staff have been suitably housed attention should be directed to the highly important features of shops, industrial equipment, gymnasium and gardens. If no suitable buildings close to the hospital can be secured, perfectly adequate facilities can be provided in cheaply constructed wooden huts with concrete floors. A gymnasium can be erected more cheaply than an existing building can be adapted for this purpose unless a large storehouse, barn or factory is available.

Hydrotherapeutic equipment should include continuous baths, Scotch douche, needle baths and a swimming pool. The latter is exceptionally valuable in the treatment of functional paralyses and disturbances of gait which disappear while patients are swimming, thus often opening the way for rapid recovery by persuasion.

Electrical apparatus is necessary for diagnostic purposes and also for general and local treatment.

Second in importance only to the general psychological control of the situation in functional nervous diseases* is the restoration of the lost or impaired functions by re-education. None of the methods available for re-education are so valuable in the war neuroses as those in which a useful occupation is employed as the means for training. Re-education should commence as soon as the patient is received. Thought, will, feeling and function have all to be restored and work toward all these ends should be undertaken simultaneously. Non-productive occupations are not only useless but deleterious. The principle of "learning by doing" should guide all re-educative work. Continual "resting," long periods spent alone, general softening of the environment and occupations undertaken simply because the mood of the patient suggests them are positively harmful, as shown by the poor results obtained in those general hospitals and convalescent homes in which such measures are employed.

The industrial equipment needed is relatively simple and inexpensive. It is very desirable to begin with a few absolutely necessary things and to add those made by the patients themselves. When this is done every piece of apparatus is invested, in the eyes of the patients, with the spirit of achievement through persistent effort—the very keynote of treatment. The fact that it has been made by patients recovering from neuroses will help hundreds of subsequent patients through the force of hopeful suggestion. The following list gives the equipment for the shops which is necessary at the beginning:

Smiths' shop
    Forges, tools, etc. for ten men
Fitting shop
    One screw-cutting lathe, one sensitive drill, one polishing machine, one electric motor 1½ h.p., swages and tools for eight men

*See pp. 522, 523.

Leather blocking room
Sewing machine, eyeletting machine, tank, galvanized iron and tools

Tailors' shop
Three sewing machines, tools for ten men

Carpenters' shop
Selected tools for fifteen men, bench screws and special tools not for general use, wood-turner's lathe

Machine shop
Electric motor 8½ h.p., with shafting, brackets, etc.

Cement shop
Metal moulds, tools for twelve men

Printing shop
Press and accessories

General
Drilling machine, grindstone, screw-cutting lathe, fret-saw workers' machine and patterns, circular-saw bench

Practically all gymnasium apparatus can be made in the shops after the hospital is opened.

Each special base hospital should be able to evacuate patients who, although not quite able to return to active duty, no longer require intensive treatment. For this purpose one or more convalescent camps within convenient distance by motor truck from the main institution should be established. Each of these convalescent camps should not exceed 100 in capacity. It will require only one medical officer, one sergeant, three female nurses, an instructor and three or four hospital corps men, as the patients will be able to care for themselves and in a short time return to duty.

One camp may have to be established for the care of another type of cases. It is conceivable that submarine activity will interfere so seriously with the evacuation of chronic and non-recoverable cases to the United States that the special hospital will be overcrowded. Overcrowding will instantly interfere with the success of the work and this will simply mean that men who otherwise might recover and return to military duty at the front will fail to do so. Such a calamity can be averted by transferring chronic and non-recoverable cases to a camp organized upon quite simple lines under direct control of the main hospital and near enough to utilize its therapeutic resources. The beds which such patients would otherwise occupy in the special base hospital can be made available for the use of fresh, recoverable cases. Such developments might better be made naturally as circumstances require than provided for by any formal arrangements made in advance.

Each base hospital should have the personnel enumerated in the following table:

PERSONNEL FOR SPECIAL BASE HOSPITAL FOR NEURO-PSYCHIATRIC CASES

Commissioned Officers		
Major	M.C.	Commanding Officer
Captain	M.C.	Adjutant, Surgeon of the Command, Recruiting Officer
Captain	Q.C.	Quartermaster
Major	M.R.C.	Director
Major	M.R.C.	Chief Neurological Division
Major	M.R.C.	Chief Psychiatrical Division
Major	M.R.C.	Chief Occupational Division
Captain	M.R.C.	Pathologist
Captain	M.R.C.	In charge of Convalescent Camp
Captain	M.R.C.	In charge of Electrotherapy and Hydrotherapy
Captain	M.R.C.	Ward Physician (in charge of Transportation of Patients)
Captain	M.R.C.	Ward Physician
Captain	M.R.C.	Ward Physician
1st Lieutenant	M.R.C.	Ward Physician
1st Lieutenant	M.R.C.	Ward Physician
1st Lieutenant	M.R.C.	Ward Physician
1st Lieutenant	M.R.C.	Ward Physician
1st Lieutenant	M.R.C.	Ward Physician
1st Lieutenant	San.C.	Psychologist
1st Lieutenant	San.C.	Registrar
Non-Commissioned Officers		
Sergeant, 1st Cl.	H.C.	General Supervision
Sergeant, 1st Cl.	Q.C.	Quartermaster Sergeant
Sergeant, 1st Cl.	H.C.	Office
Sergeant, 1st Cl.	H.C.	In charge of Detachment and Detachment Accounts
Sergeant, 1st Cl.	H.C.	In charge of Mess and Kitchen
Sergeant, 1st Cl.	H.C.	General Supervision, Convalescent Camp
Sergeant, 1st Cl.	H.C.	In charge of Shops
Sergeant, 1st Cl.	H.C.	In charge of Garden and Grounds
Sergeant	H.C.	Hydrotherapy Rooms
Sergeant	H.C.	Electrotherapy Rooms
Sergeant	H.C.	Massage Rooms
Sergeant	H.C.	Shops
Sergeant	H.C.	Gymnasium
Sergeant	H.C.	Mess and Kitchen
Sergeant	H.C.	Storerooms
Sergeant	H.C.	Office
Sergeant	H.C.	Office
Sergeant	H.C.	Outside Police
Sergeant	H.C.	Wards
Sergeant	H.C.	Wards
Sergeant	H.C.	Wards
Sergeant	H.C.	Wards
Sergeant	H.C.	Wards
Sergeant	H.C.	Transportation of Patients

FEMALE NURSES (N.C.)

Chief nurse	1	
Assistant to Chief Nurse	1	
Dietist	1	46
Ward Nurses	43	

ENLISTED MEN (H.C.)

14 Acting Cooks

115 Privates, 1st Cl. and Privates

Distributed as follows:

Ward Attendants		
Neurological Division	22	
Psychiatrical Division	26	52
Convalescent Camp	4	
Shops		10
Electrotherapy rooms		4
Hydrotherapy rooms		4
Massage rooms		6
Laboratory		2
Kitchens and mess		14
Office		5
Storerooms		6
Orderlies		4
Outside Police		4
Supernumeraries		4
		115

CIVILIAN EMPLOYEES

Instructors		
Outdoor occupations	1	2
Indoor occupations	1	
Assistant Instructors		
Carpentry and wood carving	1	
Cement work	1	
Metal work	1	
Leather work	1	8
Gardening	1	
Printing	1	
Gymnasium	2	
Stenographers		4
Photographer		1
Laboratory technician		1
		16

RECAPITULATION

Commissioned officers	20
Non-commissioned officers	24
Female nurses	46
Enlisted men	129
Civilian employees	16
	235

The commissioned medical officers should all be men with excellent training in neurology and psychiatry. The neurologists should have a psychiatrical outlook and the psychiatrists should be familiar with neurological technique. Of importance almost equal to the professional qualifications of these officers is their character and tact, and no man who is unable to adjust his personal problems should be selected for this work. There is no place in such hospital for a "queer," disgruntled or irritable individual except as a patient. Men who are strong, forceful, patient, tactful and sympathetic are required. It is better to permit a medical officer not having these qualifications to remain at home than to assign him to one of these hospitals and allow him to interfere with treatment by his failure to establish and maintain proper contact with his patients. The resources to be employed include psychological analysis, persuasion, sympathy, discipline, hypnotism, ridicule, encouragement and severity. All are dangerous or useless in the hands of the inexperienced, as the records of "shell shock" cases treated in general hospitals testify. In the hands of men capable of forming a correct estimate of the make-up of each patient and of employing these resources with reference to the therapeutic problem presented by each case, they are powerful aids.

The female nurses should have had experience in the treatment of mental and nervous diseases. Character and personality are as important in nurses as in medical officers. A large proportion of college women will be found advantageous.

The enlisted men who perform the duties of ward attendants and assistants in the shops, gardens and gymnasium should include a considerable number of those who have had experience in dealing with mental and nervous diseases. The civilian employees who act as instructors should all have had practical experience in the use of occupations in the treatment of nervous and mental diseases. The instructor for bed occupations should be a woman and she should train the female nurses to assist her in this kind of work.

No work is more exacting than that which will fall to the physicians and chief lay employees in such hospital. Success in treatment depends chiefly upon each person's establishing and maintaining a sincere belief in the work to which he or she is assigned. No hysterical case must be regarded as hopeless. The maintenance of a correct attitude and constant co-operation be-

tween physicians, nurses, instructors and men in the face of the tremendous demands which neurotic patients make upon the patience and resourcefulness of those treating them soon bring weariness and loss of interest if opportunities for recreation do not exist. Therefore, it should be the duty of the director to see that the morale and good spirits of all are kept up. His recommendations as to the transfer to other military duties of medical officers, nurses, instructors or men who prove unsuited for this work should be acted upon whenever possible by the chief surgeon under whom the hospital serves. A man or a woman may prove unadapted to this work and yet be a valuable member of the staff of another kind of hospital. This subject is mentioned so particularly because of its great importance. The type of personnel will determine the success of this hospital and hence its usefulness to the army in a measure which is unknown in other military hospitals. It does not greatly matter whether the operating surgeon understands the personality of the soldier upon whom he is operating or not. Whether or not the physician treating a case of "shell shock" understands the personality of his patient spells success or failure.

The first special base hospital established for neuro-psychiatric cases should have so highly efficient a personnel that it will be able to contribute one third of its medical officers and trained workers to the next similar base hospital to be established, filling their places from those on its reserve list. This should be repeated a second time if necessary and thus a uniform standard of excellence and the same general approach to problems of treatment assured in each special base hospital organized in France.

(b) *Advanced Section of Lines of Communication.* The French and the British experience shows the great desirability of instituting treatment of "shell shock" cases as early as possible. So little has been done as yet in this direction that we do not know much about the onset of these cases and just what happens during the first few days. Such information as has been contributed, however, by the few neurologists and psychiatrists who have had an opportunity of working in casualty clearing stations or positions even nearer the front indicates that much can be done in dealing with these cases if they can be treated within a few hours after the onset of severe nervous symptoms. There are data to show that even by the time these cases are received at base hospitals additions have been made to the initial neurological disability and a

coloring of invalidism given which frequently influences the prospects of recovery. It is desirable, therefore, to provide neuro-psychiatric wards for selected base hospitals in the advanced section of the lines of communication. Other base hospitals can send cases to those which possess such wards. The plan of providing such sections, in charge of neurologists and psychiatrists, for divisional base hospitals in the cantonment camps in the United States has been adopted by the Surgeon-General. If it is found practicable to make similar provisions in France, these units can accompany the divisions to which they are attached when they join the expeditionary forces in the spring of 1918. In the meantime it is essential that each base hospital should have on its staff a neurologist or a psychiatrist. Provision for the care of mental and nervous cases nearer the front, along the lines of communication, can best be developed, after the first special base hospital for neuro-psychiatric cases has been established, by detaching from its staff individual officers as actual circumstances require.

It is undesirable to formulate plans for providing this kind of care still nearer the fighting line until a more careful study has been made of the results obtained by the English and French medical services in this undertaking.

The foregoing recommendations are illustrated graphically in the upper part of the accompanying chart from Major Pearce Bailey's recent paper.*

II. IN THE UNITED STATES

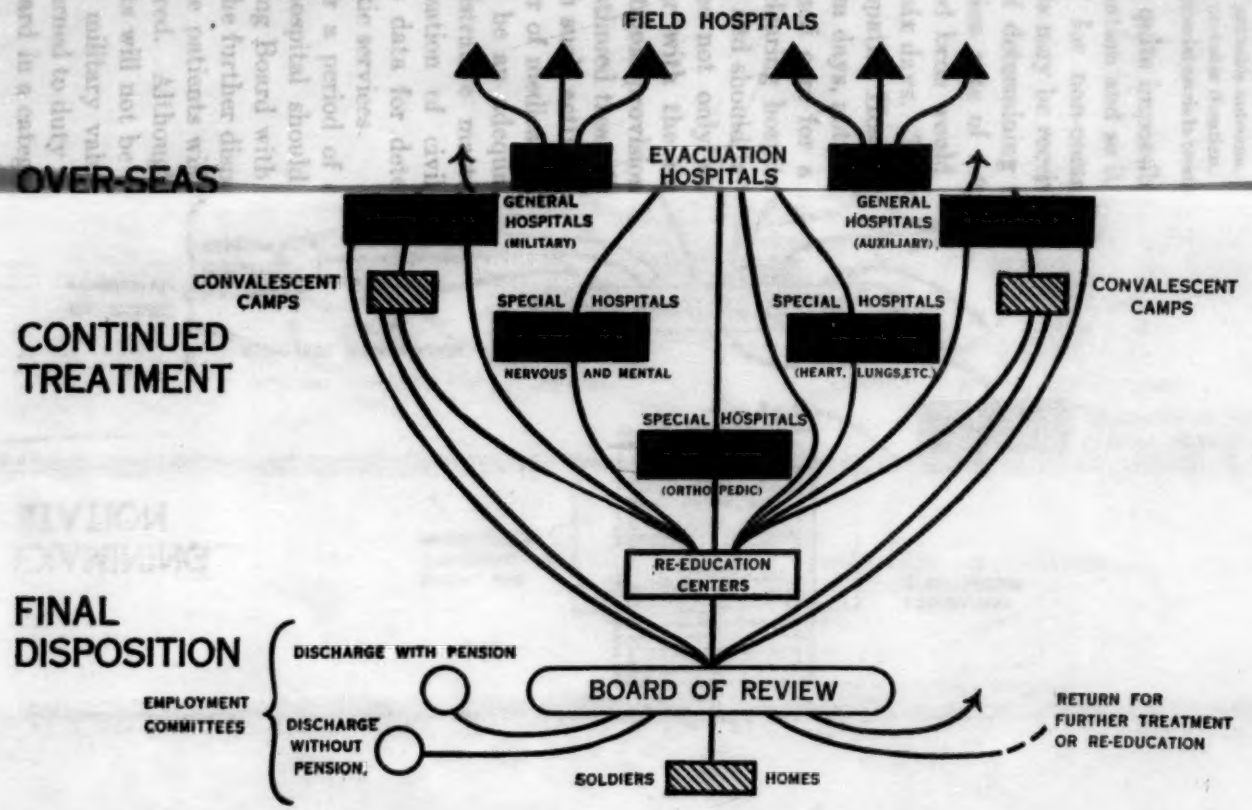
(a) *Mental Diseases* (*Insanity*). If the policy is adopted of caring in France for mental cases likely to recover and evacuating all others to the United States at once or at the expiration of six months' treatment, we may expect to receive at the port of arrival in the United States not less than 250 insane soldiers per month from an expeditionary force of 1,000,000. We may assume that a plan will be adopted for the reception and the distribution of soldiers invalided from France such as proposed by Major Bailey.

Well-organized facilities for dealing with mental disease exist in the United States which can be utilized by the government without the necessity of creating expensive new agencies. It is obvious that the first facts to be determined in the case of soldiers

* MENTAL HYGIENE, Vol. I, No. 3 (July, 1917).

CAREER OF DISABLED RETURNED SOLDIERS

(SPEARHEADS INDICATE RETURN TO THE COLORS)



coloring of invalidism given which frequently influences the prospects of recovery. It is desirable, therefore, to provide neuro-psychiatric wards for selected base hospitals in the advanced section of the lines of communication. Other base hospitals can send cases to those which possess such wards. The plan of providing such sections, in charge of neurologists and psychiatrists, for divisional base hospitals in the cantonment camps in the United States has been adopted by the Surgeon-General. If it is found practicable to make similar provisions in France, these units can accompany the divisions to which they are attached when they join the expeditionary forces in the spring of 1918. In the meantime it is essential that each base hospital should have on its staff a neurologist or a psychiatrist. Provision for the care of mental and nervous cases nearer the front, along the lines of communication, can best be developed, after the first special base hospital for neuro-psychiatric cases has been established, by detaching from its staff individual officers as actual circumstances require.

It is undesirable to formulate plans for providing this kind of care still nearer the fighting line until a more careful study has been made of the results obtained by the English and French medical services in this undertaking.

The foregoing recommendations are illustrated graphically in the upper part of the accompanying chart from Major Pearce Bailey's recent paper.*

II. IN THE UNITED STATES

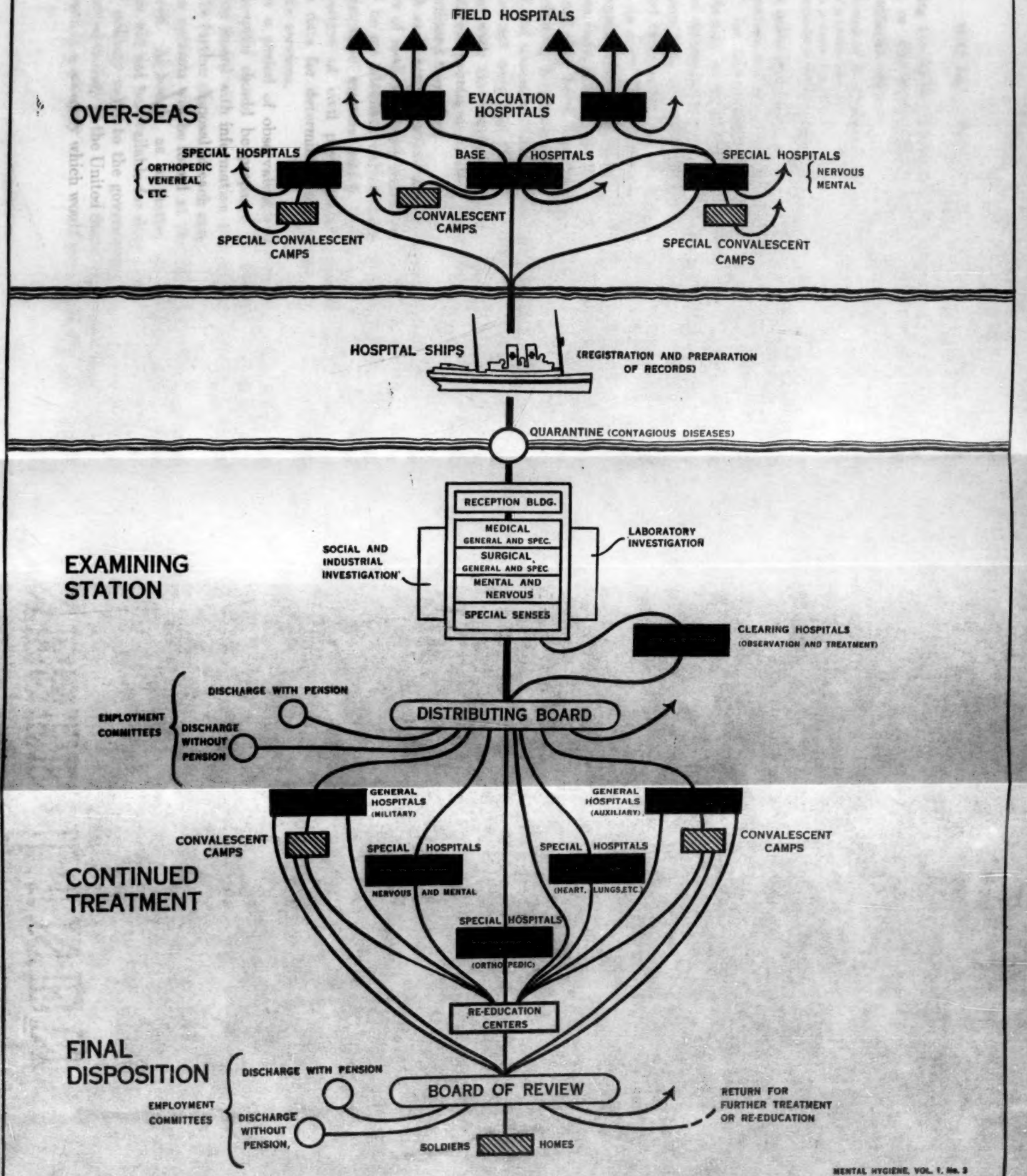
(a) *Mental Diseases* (*Insanity*). If the policy is adopted of caring in France for mental cases likely to recover and evacuating all others to the United States at once or at the expiration of six months' treatment, we may expect to receive at the port of arrival in the United States not less than 250 insane soldiers per month from an expeditionary force of 1,000,000. We may assume that a plan will be adopted for the reception and the distribution of soldiers invalided from France such as proposed by Major Bailey.

Well-organized facilities for dealing with mental disease exist in the United States which can be utilized by the government without the necessity of creating expensive new agencies. It is obvious that the first facts to be determined in the case of soldiers

* MENTAL HYGIENE, Vol. I, No. 3 (July, 1917).

CAREER OF DISABLED RETURNED SOLDIERS

(SPEARHEADS INDICATE RETURN TO THE COLORS)



CAREER OF DISABLED RETURNED SOLDIERS

(SHOWING THE RIGHT TO INSTITUTE RETURN INDICATED BY ARROWHEADS)

reaching the United States while still suffering from mental disorders or who have been invalided home after recovery from acute attacks, are:

1. The cause of the disorder, with special reference to military service.
2. The probable outcome.
3. The probable duration.
4. The special needs in treatment.

It is quite impossible to ascertain any of these facts by casual examination and so it will be necessary to provide "clearing hospitals" for non-commissioned officers and enlisted men where patients may be received and studied upon their arrival with the view of determining these questions. With an average annual admission rate of 3,000 patients, a clearing hospital of three hundred beds would permit an average period of treatment of thirty-six days. This would seem to be sufficient as the Boston Psychopathic Hospital, during an average period of treatment of eighteen days, not only determines similar questions but provides continued care for a considerable number of recoverable cases. Such clearing hospitals should be established near the port of arrival and should be essentially military hospitals, with directors who are not only well trained in their medical duties but are familiar with the requirements of military life and with the institutional provisions in the United States that can be utilized for continued treatment.

With such active service as a clearing hospital will have, the number of medical officers should be not less than ten and there should be an adequate clerical force to care for the important administrative matters which would require attention. The organization of civil psychopathic hospitals in this country affords data for determining the proper size of the ward and domestic services.

After a period of observation and treatment the director of such hospital should be prepared to furnish the Special Distributing Board with information and definite recommendations as to the further disposal of each case.

Some patients will be found at the clearing hospitals to have recovered. Although, as a matter of military policy, these patients will not be available for duty again in France, they are still of military value to the government. Such soldiers should be returned to duty in the United States by the Special Distributing Board in a category which would prevent their being exposed

again in the fighting line but which would indicate precisely the work for which they are suited. We can conceive of many such soldiers who are likely to break down again under the stress of actual fighting but who are quite likely to remain in good health if they are not so exposed. These men will have had valuable military experience and could render efficient service as instructors in training camps or in the performance of other military duties in the United States. Others who have recovered will give evidence of possessing such an unstable or inferior mental make-up that no further military life, even in the United States, is desirable. In such cases, recommendations should be made by the directors of the clearing hospitals to the Special Distributing Board to discharge them to their homes, with or without pensions as the circumstances demand.

There will be found others who have not been benefited at all by treatment in France and who suffer from mental disorders with an extremely unfavorable outlook for recovery. When this conclusion seems justified, the directors of the clearing hospitals should recommend these cases for transfer to a suitable public or private institution in the states from which they enlisted and their discharge from the army, with or without pension as the circumstances demand.

Another group of cases will be made up of those suffering from psychoses which are probably recoverable. It is equally to the advantage of the army, the community and the patient that such soldiers be given continued treatment. Facilities for the care of mental diseases vary so greatly in many of the states that neither the army nor the patients can receive any assurance that proper treatment will be afforded if such soldiers are discharged to the public institution nearest their homes. In such cases the important question of discharge, with or without pension, should be deferred until every facility has been given, during a reasonable period of time, for recovery to take place. It is recommended, therefore, that these cases be retained in the army until their recovery or until the end of the war and ordered for treatment to state hospitals with which the Secretary of War has made contracts. A government hospital for the insane would be the most suitable for carrying out such treatment but the present excellent institution in Washington has reached the size of 3,135 beds and can care for few additional military cases. It is highly desirable that the government should now establish a military hospital

for mental diseases for the army and navy and permit the government hospital to devote all its resources to its civil duties. It would be impossible, however, to have such institution ready within two years. If it were possible to construct such new government hospital in a shorter time, it would still be necessary to provide for treatment by contract, for this institution would probably have to care for not more than 1,500 military cases during peace. A much larger number is to be expected during the war.

It is wiser to care for insane soldiers during the war under contract at ten or twelve first-class hospitals with fully adequate facilities for treatment than to distribute them solely with reference to the location of their homes. This will involve a certain hardship through making it difficult for such men to be visited by their relatives and friends but it is possible to distribute the contract hospitals over the country in such way that there would be few cases more than a day's journey from their homes. The primary object is to insure recovery in all recoverable cases. This should outweigh all other considerations.

The legislation permitting the Secretary of War to make such contracts should state clearly that they shall be made only with institutions possessing facilities for treatment laid down by the Surgeon-General. A list of such facilities, prepared by the National Committee for Mental Hygiene for another purpose, is appended* as it may form a useful guide in this connection. The contract hospitals should be required to devote an entire building of approved construction to military cases or to erect temporary structures meeting the necessary requirements for this purpose.

In order that the army may be able to discharge mental cases cared for under contract promptly upon their recovery or upon ascertaining that recovery is unlikely, it is desirable that a special board of three medical officers should be established to visit the institutions constantly and act as a Board of Survey. If a medical officer in each contract hospital were appointed in the Medical Reserve Corps and assigned to the duty of caring for army patients he could serve as a member of such board when convened at his hospital and make it possible for the three general members to cover much more ground.

Clearing wards for officers should be established to serve the special purposes indicated in the description of the clearing hos-

*P. 546.

pitals for enlisted men. Such wards should provide for the reception, classification, and treatment in cases likely to be of short duration. They might be established in connection with general hospitals at the port of arrival or in connection with very efficient private institutions for the insane in which full military control of this department could be secured.

It is equally important to provide for the continued treatment of officers and not to leave this question, in which the army has so great an interest, to choice or geographical convenience. Arrangement similar to those for the continued care of enlisted men in public contract hospitals could easily be made with the best, endowed private institutions for the insane.

(b) *War Neuroses* ("*Shell Shock*"). It is not necessary here to outline the organization of reconstruction centers for the treatment of war neuroses in the United States. The general principles in treatment described in the foregoing report and in the plan recommended for France should be a guide in the development of those centers.

It should be remembered that if the policy recommended of evacuating to the United States only the patients who fail to recover in six months in France is adopted, some very intractable cases will be received. For the most part these will be patients with a constitutional neuropathic make-up—the type most frequently seen in civil practice. Many of these cases will prove amenable to long-continued treatment and much can be expected from the mental effect of return to the United States. It is very important not to fall into the mistake made in England of discharging these severe cases with a pension because of the discouraging results of treatment. To do so will swell the pension list enormously, as can be seen by the fact that 15 per cent of all discharges from the British Army are unrecovered cases of mental diseases and war neuroses. Quite aside from financial considerations, however, is the injustice of turning adrift thousands of young men who developed their nervous disability through military service and who can find in their home towns none of the facilities required for their cure. It is recommended, therefore, that *no soldiers suffering from functional nervous diseases be discharged from the army until at least a year's special treatment has been given.* Furloughs can be given when visits home or treatment in civil hospitals will be beneficial but the government should neither evade the responsibility nor surrender the right to

direct the treatment of these cases. A serious social and economic problem has been created in England already through the establishment in its communities of a group of chronic nervous invalids who have been prematurely discharged from the only hospitals existing for the efficient treatment of their illness. So serious is this problem that a special sanitarium "The Home of Recovery"—the first of several to be provided—has been established in London and subsidized by the War Office for the treatment of such cases among pensioners.

It is highly important not to permit convalescent cases of this kind to be cared for in the ordinary type of convalescent camp or home. The surroundings so suitable for convalescents from wounds or other diseases are very harmful to neurotic cases. Here much that has been accomplished in special hospitals by patient, skilful work is undone. Therefore, special convalescent camps similar to those recommended for the expeditionary forces in France should be established within convenient reach of the reconstruction centers.

The special board recommended for the final disposition of mental cases should deal with cases of functional nervous diseases.

NON-EXPEDITIONARY FORCES

Facilities for the treatment of neuro-psychiatric cases at the camps in the United States have been approved by the Surgeon-General and are now being provided. These will undoubtedly prove sufficient for dealing temporarily with mental cases developing in the non-expeditionary forces. Their final disposition should be made by means of the same mechanism recommended for expeditionary patients who are invalided home, except that the functions of the clearing hospital for mental diseases can be performed by the neuro-psychiatric wards of divisional hospitals and that of the special board by the Board of Survey composed of the neurologists and psychiatrists stationed at the camps.

Neuroses are very common among soldiers who have never been exposed to shell fire and will undoubtedly be seen frequently among non-expeditionary troops in this country. In England nearly 30 per cent of all men from the home forces admitted to one general hospital were suffering from various neuroses.* Most of these were men of very neurotic make-up. Many had

*Burton-Fanning, F. W. Neurasthenia in soldiers of the home forces. *Lancet* (London). 1: 907–11 (June 16, 1917).

had previous nervous breakdowns. Fear, even in the comparatively harmless camp exercises, was a common cause of neurotic symptoms. Heart symptoms were exceedingly common. The same experience in our own training camps can be confidently predicted.

The responsibility of the government in such cases is obviously different from that in soldiers returning from duty abroad. In the neuro-psychiatric wards of divisional hospitals the important and difficult question of diagnosis can be well determined. Most such cases should be discharged from the service. Some can be treated at the reconstruction centers for, unfortunately, there are scarcely any provisions in the United States for the treatment of the neuroses except in the case of the rich. It is freely predicted in England that the wide prevalence of the neuroses among soldiers will direct attention to the fact that this kind of illness has been almost wholly ignored while great advances have been made in the treatment of all others. In civil life one still hears of detecting hysteria, as if it were a crime and, although the wounded burglar is carefully and humanely treated in the modern city hospital, the hysteric is usually driven away from its doors. Today the enormous number of these cases among some of Europe's best fighting men is leading to a revision of the medical and popular attitude toward functional nervous diseases.

FACILITIES NEEDED FOR EFFICIENT TREATMENT OF MENTAL DISEASES IN A MODERN PUBLIC INSTITUTION

For the treatment of any class of the sick these fundamental provisions are required: sanitary housing, good food, good clothing, skill, kindliness and appreciation of the aims of the hospital on the part of all those charged in any way with the care or supervision of patients. These fundamental provisions must be made effective by a sound administrative system, free from political or other selfish control, in which the medical and scientific purposes of the hospital are primary considerations. With these provisions constituting the absolutely essential ground work for the treatment of any class of the sick, the following may be stated to constitute the facilities needed for the modern treatment of mental diseases in a public institution for the insane:

1. Direction of the administration of the hospital and leadership in its medical work by a physician trained in the diagnosis and treatment of mental diseases.

2. An adequate medical staff, organized so that duties are divided in accordance with the training of its different members and with the requirements of the clinical work.
3. Regular and frequent conferences of the medical staff at which the diagnosis, treatment and prognosis of each new case admitted are considered and at which cases about to be discharged are presented, training in psychiatry for new members of the staff being considered a special object.
4. The reception of all new cases in a special department or in special wards where they may receive careful individual study and where those with recoverable psychoses may receive continuous individual treatment.
5. Classification of all patients with reference to their special needs and their clinical condition, such classification being flexible enough to permit frequent changes.
6. A system of clinical records which permits study and review of the history of cases even after they have been discharged.
7. A laboratory in which some of the more useful tests required for the study and diagnosis of mental diseases as well as for those required in general clinical diagnosis can be made and in which pathological material can be studied.
8. Provision for special treatment such as hydrotherapy and electrotherapy.
9. Provision for examination and treatment by dentists, opthalmologists, gynecologists, and other specialists.
10. An adequate number of trained nurses and the maintenance of a school for nurses, under the direction of a supervisor of nurses who should have not only training in general nursing but special training in nursing patients with mental diseases.
11. The employment of female nurses in the reception and infirmary wards for men.
12. The systematic use of occupations, for their therapeutic effects, under the direction of workers specially trained for this duty.
13. Special attention to recreation and diversion, with reference to their therapeutic value.
14. Liberal use of parole especially for quiet, chronic patients who can live in farmhouses.
15. Special provision for the tuberculous.

INSANE, FEEBLEMINDED, EPILEPTICS AND INEBRIATES IN INSTITUTIONS IN THE UNITED STATES, JANUARY 1, 1917

HORATIO M. POLLOCK, PH.D.

Statistician, New York State Hospital Commission; Consulting Statistician, National Committee for Mental Hygiene

EDITH M. FURBUSH, A.B., B.S.

Statistician, National Committee for Mental Hygiene

IN order to ascertain the extent of institutional care of the insane, feebleminded, epileptics and inebriates in the several states of the Union, the National Committee for Mental Hygiene took a census on January 1, 1917, of the patient population of the institutions caring for these classes throughout the country. Responses were promptly received from most of the institutions. Those not replying to the first request were appealed to a second or third time, and the data with respect to state institutions were thus finally made complete. More difficulty was experienced in securing the census of private institutions and the figures relating to such institutions are necessarily somewhat deficient. It is believed, however, that the number of patients in private institutions concerning which we have no record is comparatively small and consequently would but slightly affect the totals and ratios given in the tables.

The institutions represented in the tables, which comprise practically all those in the country caring for the classes enumerated, except almshouses, jails, reformatories and penal institutions, may be classified as follows:

1. Number of institutions represented	571
a. Public	346
b. Private	225
2. Public institutions for insane	
a. State hospitals	156
b. County or city institutions (not including those for temporary care)	109
c. Institutions for temporary care	17
3. State institutions for feebleminded	32
4. State institutions for feebleminded and epileptics	6
5. State institutions for epileptics	11
6. State institutions for inebriates	4

7. Private institutions
   a. Having insane only..... 48
   b. Having feebleminded only..... 30
   c. Having epileptics only..... 4
   d. Having inebriates only..... 23
   e. Having more than one of these classes.... 120

Census of Public and Private Institutions

(See Table I, page 556.)

INSANE

The census shows that there were 234,055 insane patients under treatment in institutions in the United States on January 1, 1917. Of these, 225,824 were in public institutions and 8,231 in private hospitals. Of those in public institutions, 203,206 were cared for in state hospitals, 21,857 in county or city institutions, and 761 in institutions for temporary care.

Every state in the Union has one or more state hospitals for the care of the insane; in all but eight states the care of the insane is exclusively a state function. In these eight states, viz: Indiana, Iowa, Michigan, Missouri, New Jersey, Pennsylvania, Tennessee and Wisconsin, the burden of the insane is in part borne by the cities or counties. Wisconsin is the only state in which the number of the insane under county care exceeds the number under state care.

The institutions for temporary care include psychopathic hospitals or psychopathic wards in general hospitals and a few detention hospitals. Psychopathic hospitals and wards are found in Illinois, Massachusetts, Michigan, New York, Ohio, and Pennsylvania. Nearly all large cities and a few counties have detention wards either in hospitals or correctional institutions. In most instances the population of these has not been enumerated on account of the rapidity of movement. However, in California, Colorado, Illinois, Louisiana and Michigan, there are detention hospitals in which patients remain for a sufficient length of time, and in which an attempt is made to institute treatment, which would warrant our including these institutions in this census.

Private institutions for the care of the insane are found in thirty states. In most states the number under treatment in these institutions is very small compared with the number found in public institutions.

The following summary gives the number and per cent distribution of the patients cared for in each kind of institution:

Insane in Institutions, 1917

	Number	Per cent
Public institutions	225,824	96.5
State hospitals	203,206	86.9
County and city institutions	21,857	9.3
Institutions for temporary care	761	0.3
Private institutions	8,231	3.5
Total	234,055	100.0

FEEBLEMINDED

It is generally estimated that the total number of the feebleminded in the country exceeds that of the insane, but much greater institutional provision for the latter class is found in every state of the Union.

The census shows a total of 37,220 feebleminded persons in institutions throughout the country. Of these, 34,404 were in public institutions and 2,816 in private institutions. State institutions were caring for 31,361 and other public institutions, for 3,043. California, Colorado, Connecticut, Illinois, Indiana, Iowa, Kansas, Kentucky, Maine, Maryland, Massachusetts, Michigan, Minnesota, Missouri, Montana, Nebraska, New Hampshire, New Jersey, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Dakota, Vermont, Virginia, Washington, Wisconsin and Wyoming maintain state institutions for the feebleminded. In the remaining states this class is to be found in the hospitals for the insane.

Feebleminded cases are found in private institutions in twenty-eight states but in only four states does the number thus cared for reach 100.

A summary of the distribution of the feebleminded cases in institutions is shown in the following tabulation:

Feebleminded in Institutions, 1917

	Number	Per cent
Public institutions	34,404	92.4
State	31,361	84.3
Other	3,043	8.1
Private institutions	2,816	7.6
Total	37,220	100.0

EPILEPTICS

The epileptics enumerated, which did not include those insane or feebleminded, totaled 10,801. Of these, 10,394 were cared

for in public institutions and 407 in private institutions. State institutions, proper, provided for 9,935 cases and other public institutions for 459. State institutions for epileptics are maintained in Connecticut, Indiana, Kansas, Massachusetts, Michigan, New Jersey, New York, North Carolina, Ohio, Texas and Virginia. In the remaining states this class is found either in institutions for the feebleminded or in those for the insane.

Epileptics are cared for in private institutions in twenty-one states, but in only one state does the number of cases in such institutions exceed 100.

The following is a summary of the distribution of epileptics in institutions:

Epileptics in Institutions, 1917

	Number	*Per cent*
Public institutions	10,394	96.2
State	9,935	92.0
Other	459	4.2
Private institutions	407	3.8
Total	10,801	100.0

INEBRIATES

The census showed a total of 4,891 inebriates receiving institutional care. Of these, 3,991 were in public institutions and 900 in private institutions. There were 3,086 in state institutions and 905 in other public institutions. State institutions for inebriates are found in Connecticut, Iowa, Massachusetts and Minnesota. New York City maintains an institution at Warwick. The extent of private care of inebriates throughout the country is also very meager. In New Jersey 203 cases were reported in private institutions; in every other state the number was less than 100.

The distribution of this class in institutions may be summarized as follows:

Inebriates in Institutions, 1917

	Number	*Per cent*
Public institutions	3,991	81.6
State	3,086	63.1
Other	905	18.5
Private institutions	900	18.4
Total	4,891	100.0

Increase of Insane in Institutions Compared with Increase of the General Population

(See Table II, page 558.)

According to estimates of the Federal Census Bureau, the population of the United States increased from 91,972,266 on April 15, 1910, to 102,826,309 on January 1, 1917, an increase of 11.80 per cent. The insane in institutions according to the Federal Census of January 1, 1910, and the census of the National Committee for Mental Hygiene of January 1, 1917, increased from 187,791 to 234,055, an increase of 24.64 per cent. The increase of the insane in institutions was relatively greater than that of the general population in every state except Arizona, Kansas, Mississippi, Nevada, and South Carolina. The states in which the disparity in increase was greatest were:

	Per cent of increase	
	General population	*Insane in institutions*
Arkansas	11.34	49.08
Florida	20.23	74.56
Illinois	9.84	27.38
Indiana	4.64	27.44
Maryland	5.63	25.31
Missouri	3.85	21.79
Nebraska	7.17	24.87
New Hampshire	2.99	20.79
North Carolina	9.62	36.64
Oklahoma	35.53	148.47

The differences in rate of increase of the general population and of the insane may be due to several causes, namely: (1) Marked additional institutional provision for the insane has been made in some of the states; this has caused the commitment to institutions of many cases formerly cared for in homes; (2) As institutions for the insane improve they become less dreaded by the public and more mild cases are admitted; (3) Laws permitting voluntary admission to institutions have been passed in several states; (4) There is a continual accumulation of chronic cases in the hospitals; (5) As the insanity rate is higher in cities than in rural districts, the rapid growth of cities becomes a factor in increasing such rate. Why these causes should produce wide differences in rate of increase in the several states can be explained only by a study of local conditions, which would include the composition of the population with respect to sex, age, race, and nativity; the environment, habits, customs and occupations

of the people; and the laws of the states relating to physical and mental diseases.

Insane in Institutions by Divisions and States, 1910 and 1917

(See Table III, page 560.)

Table III gives a comparison of the insane in institutions by divisions and states in 1910 and in 1917. A marked increase in the number of patients is noted in each division although wide variations in the rate appear. The New England division continues to rank first in the number of insane in institutions per 100,000 of population and the Middle Atlantic division second. Massachusetts ranks first among the states and New York second.

The following tabulation compares the number of patients per 100,000 of population in the several divisions at the two census periods:

Insane in Institutions in the Several Divisions of the United States per 100,000 of Population 1910 and 1917

Division	Rank in both periods	Number per 100,000 1910	1917
New England	1	298.8	326.7
Middle Atlantic	2	271.2	296.9
East North Central	4	226.0	251.1
West North Central	5	194.9	219.8
South Atlantic	6	163.6	185.0
East South Central	8	116.0	124.9
West South Central	9	95.8	116.1
Mountain	7	135.7	148.8
Pacific	3	243.4	283.8

The most rapid increase in patients per 100,000 of population is found in the Pacific division and the slowest, in the East South Central division.

The District of Columbia has relatively a higher rate of insane under treatment than any of the states, as the government institution, known as St. Elizabeth's Hospital, admits patients from the army and navy as well as residents of the district.

The insane in institutions in the United States as a whole increased from 204.2 to 227.6 per 100,000 of population during the seven-year period.

Comparison of Censuses of 1890, 1904, 1910 and 1917

(See Table IV, page 562.)

Between the Federal census of 1890 and the census of the National Committee for Mental Hygiene of 1917, 26 years and 7

months elapsed. The increase of insane per 100,000 of general population during this period was 57.6, or 2.2 per year. During the period from 1890 to 1904 the increase was 13.6 or 1 per year; from 1904 to 1910, 20.6 or 3.4 per year and from 1910 to 1917, 23.4 or 3.3 per year. The rate of increase of the insane in institutions since 1904, therefore, has been over three times as rapid as it was during the 14 years preceding 1904. No acceleration of the rate, however, has taken place during the past seven years. The rates of increase in the several states during these periods vary widely. The following are a few notable examples:

Yearly Rate of Increase of Insane in Institutions per 100,000 of Population

	From 1890 to 1917	*From 1890 to 1904*	*From 1904 to 1910*	*From 1910 to 1917*
California	0.59	0.50	−6.03	6.45
Connecticut	2.16	0.91	5.53	1.71
Illinois	3.39	1.03	6.66	5.18
Maine	−0.14	−5.31	7.53	3.31
Maryland	5.15	3.40	7.40	6.61
Massachusetts	3.89	1.16	9.36	4.50
Michigan	2.32	2.50	4.41	0.21
New York	2.63	2.36	2.25	3.50
Ohio	1.14	−0.74	4.21	2.18
Washington	3.86	3.63	2.63	5.35
Wisconsin	3.95	1.74	8.36	4.45

To account for such marked variations would require a most careful study of local conditions and of changes in population in the several states. The irregularity in making additional provision for the insane in the several states explains the variations in part, but why marked decreases should be followed by increases of like magnitude is not clear.

Insane in State Hospitals

(See Table V, page 564.)

Table V shows the number of state hospitals in each state, the number of insane patients cared for therein on January 1, 1917, and the average number per hospital. Altogether there are 156 state hospitals for the insane housing 203,206 patients, or an average of 1,303 per hospital. New York has 15 state hospitals with an average of 2,451 patients per hospital; Massachusetts has 12, with an average of 1,138 patients; Illinois and Ohio each have 8, with an average of 2,013 and 1,514 patients respectively; Penn-

sylvania has 7, with an average of 1,360 patients; of the other states, 2 have 6 each; 3, 5 each; 5, 4 each; 8, 3 each; 9, 2 each; and 16, 1 each.

In 1910 there were 143 state hospitals with a total patient population of 159,096, or an average per hospital of 1,113. The data for 1917 with respect to state hospitals therefore show an increase of 13 institutions, and 44,110 patients. The average patient population per state hospital has increased 190 since 1910.

Increase of Feebleminded in Institutions

(See Table VI, page 565.)

That the movement for more adequate provision for the feebleminded in institutions is bearing fruit is clearly shown by Table VI. The feebleminded in institutions in the United States increased from 20,731 to 37,220, or 79.54 per cent, during the seven-year period from January 1, 1910 to January 1, 1917. In 1910, 17 states reported no feebleminded in institutions; in 1917, all but 4 states were making some institutional provision for this class. In 1910 the Federal Census Bureau estimated that not over one tenth of the feebleminded in the United States were being cared for in institutions. On the same basis and assuming that the increase in feebleminded has been at the same rate as the general population, there is now about one sixth of the total feebleminded population in institutions; but this is, of course, an indefinite estimate and no data have as yet been secured to support it.

This brief review of the insane and feebleminded in institutions indicates that marked progress is being made in caring for these classes of unfortunates. The number of institutions is rapidly increasing and the number of patients is mounting higher and higher. Institutions are also being much better constructed and methods of treatment are becoming more enlightened. The number of insane and feebleminded in the community with the evils associated therewith is consequently lessening.

Table I

Insane, feebleminded, epileptics and inebriates in institutions in the several states of the Union on January 1, 1917

State	Insane						Feebleminded				
	Total	Public				Private	Total	Public			Private
		Total	State hospitals	County or city institutions	Institutions for temporary care			Total	State institutions	Other institutions	
United States	234,055	225,824	203,206	21,857	761	8,231	37,220	34,404	31,361	3,043	2,816
Alabama	2,341	2,341	2,341	.....	...	.....	.....	.....	.....	.....	.....
Arizona	411	411	411	.....	...	.....	50	50	50	.....	.....
Arkansas	1,628	1,628	1,628	.....	...	.....	165	165	165	.....	.....
California	9,698	9,558	9,532	.....	26	140	1,294	1,265	1,262	3	29
Colorado	1,613	1,515	1,493	4	18	98	224	211	208	3	13
Connecticut	4,180	3,846	3,846	.....	...	334	438	432	432	.....	6
Delaware	484	484	484	.....	...	.....	30	30	30	.....	.....
District of Columbia	3,082	3,082	3,058	.....	24	.....	143	143	140	3	.....
Florida	1,482	1,482	1,482	.....	...	.....	.....	.....	.....	.....	.....
Georgia	4,062	4,009	4,009	.....	...	53	4	.....	.....	.....	4
Idaho	540	540	540	.....	...	.....	61	61	61	.....	.....
Illinois	16,354	16,272	16,104	.....	168	82	2,305	2,225	2,224	1	80
Indiana	5,769	5,746	5,496	250	...	23	1,523	1,523	1,523	.....	.....
Iowa	6,367	5,684	4,784	900	...	683	1,772	1,709	1,499	210	63
Kansas	3,157	3,108	3,108	.....	...	49	1,053	1,050	1,050	.....	3
Kentucky	4,348	4,328	4,328	.....	...	20	504	421	421	.....	83
Louisiana	2,552	2,399	2,326	.....	73	153	128	105	100	5	23
Maine	1,493	1,481	1,481	.....	...	12	376	376	376	.....	.....
Maryland	4,035	2,992	2,992	.....	...	1,043	708	688	688	.....	20
Massachusetts	14,096	13,750	13,654	.....	96	346	3,213	3,129	3,129	.....	84
Michigan	7,377	7,294	6,493	741	60	83	1,632	1,596	1,590	6	36
Minnesota	5,857	5,830	5,830	.....	...	27	1,372	1,336	1,336	.....	36
Mississippi	2,024	2,024	2,024	.....	...	.....	154	154	154	.....	.....
Missouri	7,512	7,061	4,792	2,269	...	451	633	574	444	130	59
Montana	1,083	1,083	1,083	.....	...	.....	83	83	83	.....	.....
Nebraska	2,485	2,446	2,446	.....	...	39	551	538	538	.....	13
Nevada	244	244	244	.....	...	.....	.....	.....	.....	.....	.....
New Hampshire	1,098	1,098	1,098	.....	...	.....	374	374	374	.....	.....
New Jersey	7,592	7,538	4,326	3,212	...	54	1,298	706	564	142	592
New Mexico	302	302	302	.....	...	.....	5	5	5	.....	.....
New York	38,117	36,894	36,761	.....	133	1,223	5,525	5,321	3,311	2,010	204
North Carolina	3,446	3,404	3,404	.....	...	42	205	201	201	.....	4
North Dakota	1,079	1,079	1,079	.....	...	.....	276	276	276	.....	.....
Ohio	12,307	12,134	12,108	.....	26	173	2,199	2,184	2,184	.....	16
Oklahoma	2,758	2,740	2,740	.....	...	18	708	704	704	.....	4
Oregon	2,309	2,112	2,112	.....	...	197	372	335	335	.....	37
Pennsylvania	19,436	17,582	9,522	7,923	137	1,854	4,361	3,227	2,925	302	1,134
Rhode Island	1,565	1,423	1,423	.....	...	142	244	241	241	.....	3
South Carolina	1,642	1,642	1,642	.....	...	.....	139	139	139	.....	.....
South Dakota	1,059	1,059	1,059	.....	...	.....	317	317	317	.....	.....
Tennessee	2,518	2,493	2,216	277	...	25	27	11	.....	11	16
Texas	5,033	4,880	4,880	.....	...	153	77	50	50	.....	27
Utah	474	474	474	.....	...	.....	66	66	66	.....	.....
Vermont	1,110	668	668	.....	...	442	69	59	59	.....	10
Virginia	4,398	4,398	4,398	.....	...	.....	353	257	257	.....	96
Washington	3,312	3,303	3,303	.....	...	9	550	550	550	.....	.....
West Virginia	2,127	2,127	2,127	.....	...	.....	98	98	98	.....	.....
Wisconsin	7,879	7,616	1,355	6,261	...	263	1,477	1,355	1,138	217	122
Wyoming	220	220	220	.....	...	.....	64	64	64	.....	.....

Table I—Continued

Insane, feebleminded, epileptics and inebriates in institutions in the several states of the Union on January 1, 1917

State	Epileptics not included among insane or feebleminded					Inebriates				
	Total	Public			Private	Total	Public			Private
		Total	State institutions	Other institutions			Total	State institutions	Other institutions	
United States	10,801	10,394	9,935	459	407	4,891	3,991	3,086	905	900
Alabama	.....	.....	.....	...	...	.....	.....	.....	...	...
Arizona	16	16	16	...	...	5	5	5	...	...
Arkansas	212	212	212	...	...	22	22	22	...	...
California	15	10	8	2	5	362	338	322	16	24
Colorado	140	133	133	...	7	19	5	.....	5	14
Connecticut	105	97	97	...	8	157	111	111	...	46
Delaware	5	5	5	...	...	.....	.....	.....	...	...
District of Columbia	15	15	7	8	...	40	40	10	30	...
Florida	.....	.....	.....	...	...	.....	.....	.....	...	...
Georgia	3	.....	.....	...	3	16	3	3	...	13
Idaho	40	40	40	...	...	2	2	2	...	...
Illinois	128	118	117	1	10	827	731	731	...	96
Indiana	416	415	415	...	1	46	29	29	...	17
Iowa	57	41	1	40	16	247	243	195	48	4
Kansas	622	622	622	...	...	324	320	320	...	4
Kentucky	301	300	300	...	1	54	50	50	...	4
Louisiana	125	115	110	5	10	15	6	.....	6	9
Maine	33	33	33	...	...	51	47	47	...	4
Maryland	33	.....	.....	...	33	33	.....	.....	...	33
Massachusetts	1,069	1,007	1,007	...	62	344	280	280	...	64
Michigan	358	354	346	8	4	89	72	57	15	17
Minnesota	379	379	379	...	...	147	141	141	...	6
Mississippi	76	76	76	...	...	14	14	14	...	...
Missouri	364	315	265	50	49	63	47	10	37	16
Montana	.....	.....	.....	...	...	6	6	6	...	...
Nebraska	5	1	1	...	4	28	24	24	...	4
Nevada	.....	.....	.....	...	...	.....	.....	.....	...	...
New Hampshire	.....	.....	.....	...	...	.....	.....	.....	...	...
New Jersey	696	688	688	...	8	365	162	24	138	203
New Mexico	4	4	4	...	...	3	3	3	...	...
New York	1,575	1,568	1,543	25	7	357	264	2	262	93
North Carolina	211	210	210	...	1	20	1	1	...	19
North Dakota	7	7	7	...	...	4	4	4	...	...
Ohio	1,602	1,602	1,602	...	...	116	83	82	1	33
Oklahoma	143	143	143	...	...	289	286	286	...	3
Oregon	4	1	1	...	3	11	3	3	...	8
Pennsylvania	645	482	302	180	163	429	342	23	319	87
Rhode Island	.....	.....	.....	...	...	2	.....	.....	...	2
South Carolina	188	188	188	...	...	13	6	6	...	7
South Dakota	2	2	2	...	...	.....	.....	.....	...	...
Tennessee	2	2	.....	2	...	30	3	1	2	27
Texas	514	510	510	...	4	23	.....	.....	...	23
Utah	12	12	12	...	...	.....	.....	.....	...	...
Vermont	.....	.....	.....	...	...	81	70	70	...	11
Virginia	314	314	314	...	...	53	53	53	...	...
Washington	.....	.....	.....	...	...	3	.....	.....	...	3
West Virginia	204	204	204	...	...	24	24	24	...	...
Wisconsin	146	138	.....	138	8	152	146	120	26	6
Wyoming	15	15	15	...	...	5	5	5	...	...

Table II

Comparison between increase in general population and increase in insane in institutions in the several states of the Union, from January 1, 1910 to January 1, 1917

State	General population				Insane			
	April 15, 1910	January 1, 1917*	Increase		January 1, 1910	January 1, 1917	Increase	
			Number	Per cent			Number	Per cent
United States	91,972,266	102,826,309	10,854,043	11.80	187,791	234,055	46,264	24.64
Alabama	2,138,093	2,348,273	210,180	9.83	2,039	2,341	302	14.81
Arizona	204,354	259,666	55,312	27.07	337	411	74	21.96
Arkansas	1,574,449	1,753,033	178,584	11.34	1,092	1,628	536	49.08
California	2,377,549	2,983,843	606,294	25.50	6,652	9,698	3,046	45.79
Colorado	799,024	975,190	176,166	22.05	1,199	1,613	414	34.53
Connecticut	1,114,756	1,254,926	140,170	12.57	3,579	4,180	601	16.79
Delaware	202,322	214,270	11,948	5.91	441	484	43	9.75
District of Columbia	331,069	366,631	35,562	10.74	2,890	3,082	192	6.64
Florida	752,619	904,839	152,220	20.23	849	1,482	633	74.56
Georgia	2,609,121	2,875,953	266,832	10.23	3,132	4,062	930	29.69
Idaho	325,594	436,881	111,287	34.18	388	540	152	39.18
Illinois	5,638,591	6,193,626	555,035	9.84	12,839	16,354	3,515	27.38
Indiana	2,700,876	2,826,154	125,278	4.64	4,527	5,769	1,242	27.44
Iowa	2,224,771	2,224,771			5,377	6,367	990	18.41
Kansas	1,690,949	1,840,707	149,758	8.86	2,912	3,157	245	8.41
Kentucky	2,289,905	2,386,866	96,961	4.23	3,538	4,348	810	22.89
Louisiana	1,656,388	1,843,042	186,654	11.27	2,158	2,552	394	18.26
Maine	742,371	774,914	32,543	4.38	1,258	1,493	235	18.68
Maryland	1,295,346	1,368,240	72,894	5.63	3,220	4,035	815	25.31
Massachusetts	3,366,416	3,747,564	381,148	11.32	11,601	14,096	2,495	21.51
Michigan	2,810,173	3,074,560	264,387	9.41	6,699	7,377	678	10.12
Minnesota	2,075,708	2,296,024	220,316	10.61	4,744	5,857	1,113	23.46
Mississippi	1,797,114	1,964,122	167,008	9.29	1,978	2,024	46	2.33
Missouri	3,293,335	3,420,143	126,808	3.85	6,168	7,512	1,344	21.79

* Estimates of the United States Census Bureau.

Table II—Continued

Comparison between increase in general population and increase in insane in institutions in the several states of the Union, from January 1, 1910 to January 1, 1917

State	General population				Insane			
	April 15, 1910	January 1, 1917*	Increase		January 1, 1910	January 1, 1917	Increase	
			Number	Per cent			Number	Per cent
Montana	376,053	466,214	90,161	23.98	697	1,083	386	55.38
Nebraska	1,192,214	1,277,750	85,536	7.17	1,990	2,485	495	24.87
Nevada	81,875	108,736	26,861	32.81	230	244	14	6.09
New Hampshire	430,572	443,467	12,895	2.99	909	1,098	189	20.79
New Jersey	2,537,167	2,981,105	443,938	17.50	6,042	7,592	1,550	25.65
New Mexico	327,301	416,966	89,665	27.40	219	302	83	37.90
New York	9,113,614	10,366,778	1,253,164	13.75	31,280	38,117	6,837	21.86
North Carolina	2,206,287	2,418,559	212,272	9.62	2,522	3,446	924	36.64
North Dakota	577,056	752,260	175,204	30.36	628	1,079	451	71.82
Ohio	4,767,121	5,181,220	414,099	8.69	10,594	12,307	1,713	16.17
Oklahoma	1,657,155	2,245,968	588,813	35.53	1,110	2,758	1,648	148.47
Oregon	672,765	848,866	176,101	26.18	1,565	2,309	744	47.54
Pennsylvania	7,665,111	8,591,029	925,918	12.08	15,058	19,436	4,378	29.07
Rhode Island	542,610	620,090	77,480	14.28	1,243	1,565	322	25.91
South Carolina	1,515,400	1,634,340	118,940	7.85	1,541	1,642	101	6.55
South Dakota	583,888	707,740	123,852	21.21	864	1,059	195	22.57
Tennessee	2,184,789	2,296,316	111,527	5.10	2,204	2,518	314	14.25
Texas	3,896,542	4,472,494	575,952	14.78	4,053	5,033	980	24.18
Utah	373,351	438,974	65,623	17.58	342	474	132	38.60
Vermont	355,956	364,322	8,366	2.35	990	1,110	120	12.12
Virginia	2,061,612	2,202,522	140,910	6.83	3,635	4,398	763	20.99
Washington	1,141,990	1,565,810	423,820	37.11	1,987	3,312	1,325	66.68
West Virginia	1,221,119	1,399,320	178,201	14.59	1,722	2,127	405	23.52
Wisconsin	2,333,860	2,513,758	179,898	7.71	6,587	7,879	1,292	19.61
Wyoming	145,965	182,264	36,299	24.87	162	220	58	35.80

* Estimates of the United States Census Bureau.

Table III

Insane in institutions in the United States by divisions and states, January 1, 1910 and January 1, 1917

Divisions and states	Number		Rate per 100,000 of general population	
	January 1, 1910	January 1, 1917	January 1, 1910	January 1, 1917
United States	187,791	234,055	204.2	227.6
New England	19,580	23,542	298.8	326.7
Maine	1,258	1,493	169.5	192.7
New Hampshire	909	1,098	211.1	247.6
Vermont	990	1,110	278.1	304.7
Massachusetts	11,601	14,096	344.6	376.1
Rhode Island	1,243	1,565	229.1	252.4
Connecticut	3,579	4,180	321.1	333.1
Middle Atlantic	52,380	65,145	271.2	296.9
New York	31,280	38,117	343.2	367.7
New Jersey	6,042	7,592	238.1	254.7
Pennsylvania	15,058	19,436	196.4	226.2
East North Central	41,246	49,686	226.0	251.1
Ohio	10,594	12,307	222.2	237.5
Indiana	4,527	5,769	167.6	204.1
Illinois	12,839	16,354	227.7	264.0
Michigan	6,699	7,377	238.4	239.9
Wisconsin	6,587	7,879	282.2	313.4
West North Central	22,683	27,516	194.9	219.8
Minnesota	4,744	5,857	228.5	255.1
Iowa	5,377	6,367	241.7	286.2
Missouri	6,168	7,512	187.3	219.6
North Dakota	628	1,079	108.8	143.4
South Dakota	864	1,059	148.0	149.6
Nebraska	1,990	2,485	166.9	194.5
Kansas	2,912	3,157	172.2	171.5
South Atlantic	19,952	24,758	163.6	185.0
Delaware	441	484	218.0	225.9
Maryland	3,220	4,035	248.6	294.9
District of Columbia	2,890	3,082	872.9	840.6
Virginia	3,635	4,398	176.3	199.7
West Virginia	1,722	2,127	141.0	152.0
North Carolina	2,522	3,446	114.3	142.5
South Carolina	1,541	1,642	101.7	100.5
Georgia	3,132	4,062	120.0	141.2
Florida	849	1,482	112.8	163.8
East South Central	9,759	11,231	116.0	124.9
Kentucky	3,538	4,348	154.5	182.2
Tennessee	2,204	2,518	100.9	109.7
Alabama	2,039	2,341	95.4	99.7
Mississippi	1,978	2,024	110.1	103.0
West South Central	8,413	11,971	95.8	116.1
Arkansas	1,092	1,628	69.4	92.9
Louisiana	2,158	2,552	130.3	138.5
Oklahoma	1,110	2,758	67.0	122.8
Texas	4,053	5,033	104.0	112.5

Table III—Continued

Insane in institutions in the United States by divisions and states, January 1, 1910 and January 1, 1917

Divisions and states	Number		Rate per 100,000 of general population	
	January 1, 1910	January 1, 1917	January 1, 1910	January 1, 1917
Mountain	3,574	4,887	135.7	148.8
Montana	697	1,083	185.3	232.3
Idaho	388	540	119.2	123.6
Wyoming	162	220	111.0	120.7
Colorado	1,199	1,613	150.1	165.4
New Mexico	219	302	66.9	72.4
Arizona	357	411	164.9	158.3
Utah	342	474	91.6	108.0
Nevada	230	244	280.9	224.4
Pacific	10,204	15,319	243.4	283.8
Washington	1,987	3,312	174.0	211.5
Oregon	1,565	2,309	232.6	272.0
California	6,652	9,698	279.8	325.0

Table IV

Number of insane in institutions in the United States with rates per 100,000 of general population in 1890, 1904, 1910 and 1917

State	June 1, 1890		January 1, 1904		January 1, 1910		January 1, 1917	
	Number	Rate per 100,000	Number	Rate per 100,000	Number	Rate per 100,000	Number	Rate per 100,000
United States	106,485	170.0	150,151	183.6	187,791	204.2	234,055	227.6
Alabama	1,469	97.1	1,603	82.6	2,039	95.4	2,341	99.7
Arizona	64	107.3	224	146.9	337	164.9	411	158.3
Arkansas	790	70.0	667	47.4	1,092	69.4	1,628	92.9
California	3,736	309.2	5,717	316.0	6,652	279.8	9,698	325.0
Colorado	326	79.1	754	119.0	1,199	150.1	1,613	165.4
Connecticut	2,056	275.5	2,831	287.9	3,579	321.1	4,180	333.1
Delaware	197	116.9	353	184.7	441	218.0	484	225.9
District of Columbia	1,578	684.9	2,453	823.9	2,890	872.9	3,082	840.6
Florida	351	89.7	713	116.9	849	112.8	1,482	163.8
Georgia	1,815	98.8	2,889	120.4	3,132	120.0	4,062	141.2
Idaho	83	98.4	255	115.3	388	119.2	540	123.6
Illinois	6,641	173.6	9,607	187.7	12,839	227.7	16,354	264.0
Indiana	3,291	150.1	4,358	168.7	4,527	167.6	5,769	204.1
Iowa	3,197	167.2	4,385	196.7	5,377	241.7	6,367	286.2
Kansas	1,794	125.7	2,460	158.7	2,912	172.2	3,157	171.5
Kentucky	2,729	146.8	3,058	139.1	3,538	154.5	4,348	182.2
Louisiana	910	81.4	1,585	107.0	2,158	130.3	2,552	138.5
Maine	1,299	196.5	885	124.3	1,258	169.5	1,493	192.7
Maryland	1,646	157.9	2,505	204.2	3,220	248.6	4,035	294.9
Massachusetts	6,103	272.6	8,679	288.4	11,601	344.6	14,096	376.1
Michigan	3,725	177.9	5,430	211.9	6,699	238.4	7,377	239.9
Minnesota	2,205	169.4	4,070	217.8	4,744	228.5	5,857	255.1
Mississippi	1,104	85.6	1,493	91.0	1,978	110.1	2,024	103.0
Missouri	3,418	127.6	5,103	160.8	6,168	187.3	7,512	219.6

Table IV—Continued

Number of insane in institutions in the United States with rates per 100,000 of general population in 1890, 1904, 1910 and 1917

State	June 1, 1890		January 1, 1904		January 1, 1910		January 1, 1917	
	Number	Rate per 100,000	Number	Rate per 100,000	Number	Rate per 100,000	Number	Rate per 100,000
Montana	192	145.3	543	186.3	697	185.3	1,083	232.3
Nebraska	932	88.0	1,536	138.1	1,990	166.9	2,485	194.5
Nevada	183	399.9	200	352.8	230	280.9	244	224.4
New Hampshire	961	255.2	496	118.5	909	211.1	1,098	247.6
New Jersey	3,163	218.9	4,865	229.4	6,042	238.1	7,592	254.7
New Mexico	66	43.0	113	46.5	219	66.9	302	72.4
New York	17,846	297.5	26,176	329.7	31,280	343.2	38,117	367.7
North Carolina	1,725	106.6	1,883	93.8	2,522	114.3	3,446	142.5
North Dakota	221	121.0	446	108.1	628	108.8	1,079	143.4
Ohio	7,600	207.0	8,621	196.9	10,594	222.2	12,307	237.5
Oklahoma	7	11.3	413	37.4	1,110	67.0	2,758	122.8
Oregon	640	204.0	1,285	253.2	1,565	232.6	2,309	272.0
Pennsylvania	8,482	161.3	11,521	169.5	15,058	196.4	19,436	226.2
Rhode Island	795	230.1	1,077	229.2	1,243	229.1	1,565	252.4
South Carolina	912	79.2	1,156	82.3	1,541	101.7	1,642	100.5
South Dakota	310	94.3	595	127.2	864	148.0	1,059	149.6
Tennessee	1,845	104.4	1,713	82.3	2,204	100.9	2,518	109.7
Texas	1,670	74.7	3,345	99.7	4,053	104.0	5,033	112.5
Utah	166	79.8	344	110.3	342	91.6	474	108.0
Vermont	823	247.6	887	254.8	990	278.1	1,110	304.7
Virginia	2,407	145.4	3,137	162.6	3,635	176.3	4,398	199.7
Washington	380	108.8	1,178	158.2	1,987	174.0	3,312	211.5
West Virginia	1,079	141.5	1,475	139.9	1,722	141.0	2,127	152.0
Wisconsin	3,513	208.3	5,023	232.0	6,587	282.2	7,879	313.4
Wyoming	40	65.9	96	85.8	162	111.0	220	120.7

Table V
Insane in state hospitals in the United States on January 1, 1917

State	Number of state hospitals	Number of insane	
		Total	Average per state hospital
United States	156	203,206	1,303
Alabama	2	2,341	1,171
Arizona	1	411	411
Arkansas	1	1,628	1,628
California	6	9,532	1,589
Colorado	1	1,493	1,493
Connecticut	2	3,846	1,923
Delaware	1	484	484
District of Columbia	1	3,058	3,058
Florida	1	1,482	1,482
Georgia	1	4,009	4,009
Idaho	2	540	270
Illinois	8	16,104	2,013
Indiana	6	5,496	916
Iowa	5	4,784	957
Kansas	4	3,108	777
Kentucky	3	4,328	1,443
Louisiana	2	2,326	1,163
Maine	2	1,481	741
Maryland	4	2,992	748
Massachusetts	12	13,654	1,138
Michigan	5	6,493	1,299
Minnesota	5	5,830	1,166
Mississippi	2	2,024	1,012
Missouri	4	4,792	1,198
Montana	1	1,083	1,083
Nebraska	3	2,446	815
Nevada	1	244	244
New Hampshire	1	1,098	1,098
New Jersey	2	4,326	2,163
New Mexico	1	302	302
New York	15	36,761	2,451
North Carolina	4	3,404	851
North Dakota	1	1,079	1,079
Ohio	8	12,108	1,514
Oklahoma	3	2,740	913
Oregon	2	2,112	1,056
Pennsylvania	7	9,522	1,360
Rhode Island	1	1,423	1,423
South Carolina	1	1,642	1,642
South Dakota	*2	1,059	530
Tennessee	3	2,216	739
Texas	3	4,880	1,627
Utah	1	474	474
Vermont	1	668	668
Virginia	4	4,398	1,100
Washington	3	3,303	1,101
West Virginia	3	2,127	709
Wisconsin	3	1,335	445
Wyoming	1	220	220

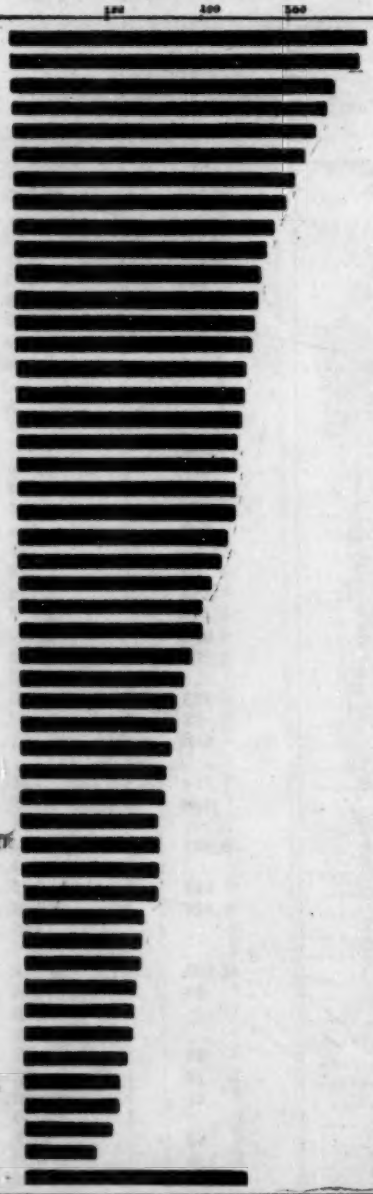
*Includes Asylum for Insane Indians.

Table VI Comparison between feebleminded in institutions in the several states of the Union on January 1, 1910, and January 1, 1917

State	January 1, 1910	January 1, 1917	Increase	
			Number	Per cent
United States	20,731	37,220	16,489	79.54
Alabama	.....	.....	.....	.....
Arizona	.....	50	50	.....
Arkansas	.....	165	165	.....
California	854	1,294	440	51.52
Colorado	64	224	160	250.00
Connecticut	294	438	144	48.98
Delaware	.....	30	30	.....
District of Columbia	.....	143	143	.....
Florida	.....	.....	.....	.....
Georgia	.....	4	4	.....
Idaho	.....	61	61	.....
Illinois	1,265	2,305	1,040	82.21
Indiana	1,135	1,523	388	34.19
Iowa	1,189	1,772	583	49.03
Kansas	420	1,053	633	150.71
Kentucky	283	504	221	78.09
Louisiana	.....	128	128	.....
Maine	62	376	314	506.45
Maryland	310	708	398	128.39
Massachusetts	1,464	3,213	1,749	119.47
Michigan	986	1,632	646	65.52
Minnesota	1,194	1,372	178	14.91
Mississippi	.....	154	154	.....
Missouri	512	633	121	23.63
Montana	51	83	32	62.75
Nebraska	446	551	105	23.54
Nevada	.....	.....	.....	.....
New Hampshire	144	374	230	159.72
New Jersey	640	1,298	658	102.81
New Mexico	.....	5	5	.....
New York	3,421	5,525	2,104	61.50
North Carolina	.....	205	205	.....
North Dakota	145	276	131	90.34
Ohio	1,526	2,199	673	44.10
Oklahoma	.....	708	708	.....
Oregon	.....	372	372	.....
Pennsylvania	2,705	4,361	1,656	61.22
Rhode Island	43	244	196	408.33
South Carolina	.....	139	139	.....
South Dakota	*.....	317	.....	.....
Tennessee	47	27	†20	†42.55
Texas	19	77	58	305.26
Utah	45	66	21	46.67
Vermont	.....	69	69	.....
Virginia	60	353	293	488.33
Washington	159	550	391	245.91
West Virginia	214	98	†116	†54.21
Wisconsin	1,029	1,477	448	43.54
Wyoming	.....	64	64	.....

*No reports.
†Decrease.

INSANE IN INSTITUTIONS IN THE UNITED STATES, PER 100,000 OF POPULATION ON JANUARY 1, 1917



1	MASSACHUSETTS	376.1
2	NEW YORK	367.7
3	CONNECTICUT	333.1
4	CALIFORNIA	325.0
5	WISCONSIN	313.4
6	VERMONT	304.7
7	MARYLAND	294.9
8	IOWA	286.2
9	OREGON	272.0
10	ILLINOIS	264.0
11	MINNESOTA	255.1
12	NEW JERSEY	254.7
13	RHODE ISLAND	252.4
14	NEW HAMPSHIRE	247.6
15	MICHIGAN	239.9
16	OHIO	237.5
17	MONTANA	232.3
18	PENNSYLVANIA	226.2
19	DELAWARE	225.9
20	NEVADA	224.4
21	MISSOURI	219.6
22	WASHINGTON	211.5
23	INDIANA	204.1
24	VIRGINIA	199.7
25	NEBRASKA	194.5
26	MAINE	192.7
27	KENTUCKY	182.2
28	KANSAS	171.5
29	COLORADO	165.4
30	FLORIDA	163.8
31	ARIZONA	158.3
32	WEST VIRGINIA	152.0
33	SOUTH DAKOTA	149.6
34	NORTH DAKOTA	143.4
35	NORTH CAROLINA	142.5
36	GEORGIA	141.2
37	LOUISIANA	138.5
38	IDAHO	123.6
39	OKLAHOMA	122.8
40	WYOMING	120.7
41	TEXAS	112.5
42	TENNESSEE	109.7
43	UTAH	108.0
44	MISSISSIPPI	103.0
45	SOUTH CAROLINA	100.5
46	ALABAMA	99.7
47	ARKANSAS	92.9
48	NEW MEXICO	72.4
	UNITED STATES	227.6

ALIENISTS AND PSYCHIATRISTS

Notes on Divisions and Nomenclature of Mental Hygiene

E. E. SOUTHARD, M.D.
Director, Boston Psychopathic Hospital

INSANITY and mental disease are not synonymous. Insanity is a legal concept; mental disease is a medical concept.

A man is either sane or insane or indeterminate as to sanity; and there are no degrees of sanity or insanity. There is but one degree and but one kind of sanity or of insanity.

There are all degrees of mental health and mental disease. There are many kinds of mental disease.

Insanity depends upon medicolegal decisions. Mental disease is an affair of medicine alone. Sanity and mental health, decided by law and medicine respectively, characterize the same human subjects; but sanity also characterizes many subjects of mental disease. Sane subjects of mental disease are subject to mental diseases—either mild or severe—that are of a kind that does not concern the courts.

It would even be entirely permissible to say that no man is either sane or insane until properly reviewed and adjudged by courts. Such is not the point here at issue. It is enough to claim that sanity and insanity are characters such that courts decide them within the limitations of accuracy of courts.

Sanity and insanity accordingly are legal, governmental, public matters. Mental health and disease are matters of individual medicine and individual psychology, and, while of familial, district, group, or social interest, they do not necessarily approach governmental régime. Insanity is a public matter; mental disease a social, family or personal matter.

The above are commonplaces in the minds of many, perhaps of the most, advanced medical men. It is probable that many competent jurists hold identical conceptions.

I therefore propose that the medical specialists who are medicolegal aids be given the familiar and etymologically appropriate designation *alienists* and that the term *psychiatrists* be reserved for those specialists that are acting as physicians only—that the

insanity expert be spoken of as an alienist and that the mental disease expert be called a psychiatrist.

Reports could then run:

1. "As alienist, I consider this person insane. As psychiatrist, I consider this patient subject to general paresis," or

2. "As alienist, I consider this person sane. As psychiatrist, I consider him in complete mental health," or

3. "As alienist, I consider this person sane. As psychiatrist, I consider him subject to mental disease, viz., subject to a psychoneurosis of hysterical form," or

4. "As alienist, I consider this person sane. As psychiatrist, I consider him subject to dementia praecox in a mild degree," or

5. "As alienist, I consider this person sane. As psychiatrist, I consider him subject to paranoia of great severity. This mental disease (which I find as psychiatrist) I regard, in this case, as of no public interest (when I review the findings as alienist)."

These points and some others that may not be worth full presentation are given in parallel columns:

Alienists	*Psychiatrists*
Field: insanity, the insane.	Field: psychiatry, the mentally diseased.
Field: public, governmental, legal.	Field: social, private, medical.
Field: opinion for court use.	Field: medical, psychological, and socialdi agnosis and treatment.
Decisions alternative: Sanity *versus* insanity.	Decisions selective: *e. g.*, syphilitic, feeble-minded, epileptic, alcoholic, coarse brain disease, symptomatic, senescent-senile, schizophrenic, cyclothymic, psychoneurotic, etc.[1]
Insanity implies mental disease.	Sanity consistent with mental disease of mild degree or of special type.
Sanity: Insanity = 1: 0.	Mental disease of all degrees of many kinds

The major divisions of mental hygiene[2] from a practical point of view are three:

1. *Public, i. e.*, governmental, legal, forensic, statutory, official.
2. *Social, i. e.*, voluntary, privately managed, charitable, philanthropic, propagandist, prelegislative, auxiliary, initiative.
3. *Individual, i. e.*, personal, private, object of medical diagnosis and treatment, having two subdivisions:
   a Medical (in a narrow sense), psychiatric.
   b Medical (in a broader sense), psychopathological, employing both metric ("mental test") and qualitative (*e. g.*, analysis of instincts) methods.

Accepting these divisions of mental hygiene as approximations to modern view, I would now query whether the prevalent distinction between insanity and mental disease should not be followed by a corresponding improvement in the terms describing

the public and non-public experts in mental hygiene. On the forensic side of the public division of mental hygiene, let the alienist hold sway. In other divisions of mental hygiene than the public division, let the psychiatrist work. Let both psychiatrists and alienists be mental hygienists.

Mental hygiene shows signs of being a larger category than psychiatry, working out an evolution somewhat like that of hygiene in general with respect to medicine. We see signs of the following specialties in mental hygiene developing:

1. *Institutional mental hygiene*, chiefly public, officially regulative, economic, state care, interstate relations, standardizing, statistical, architectural, engineering, sanitational.
2. *Forensic or medicolegal psychiatry* (The *psychiatric* features at a minimum, the legal at the maximum: experts here proposed to be named alienists, dealing with questions of alienation ("*alienistics*"?) not primarily with psychiatric questions).
3. *Practical psychiatry* (Forensic aspects remote, medical diagnosis and treatment dominant, home and dispensary treatment encouraged, psychopathic hospital encouragement of "voluntary" and "temporary care" relations of mental patients to ward treatment).

Somewhat newer and promising specialties are these:

4. *Metric psychiatry* (Psychological psychiatry, *i. e.*, a psychiatry that uses methods developed by psychologists, commonly called "mental tests," for the purpose of the psychiatrist's diagnosis not merely in the field of feeblemindedness but broadly in the study of deterioration, to determine degrees of both "mind-lack" and "mind-loss"; of value also in the third field, "mind-twist," for the exclusion of lacks and losses).
5. *Social psychiatry* (Developing from a conjugation of social and psychiatric concepts, as social psychology has already developed from a conjugation of social and psychological concepts—employing modern methods of social service investigation and care [3] and aiming to make use of characterological and ethological categories and the available facts of the psychology of the instincts, behaviorism, vocational psychology, and the like).

Concerning 5. *Social psychiatry*, it may well be claimed that a good portion of it is nothing but pious wish. At any rate, it might be maintained, should we not separate the comparatively certain field of psychiatric social service (in which, *e. g.*, several American clinics are getting solid results) from that darkling portion of social psychiatry that lies next to social psychology? Perhaps.

A brief schema of specialties made and in the making would comprise:

MENTAL HYGIENE

1. Public Division:
   A. Institutions.
   B. Forensic Psychiatry ("Alienistics"?).

2. Social Division:
   A. Psychiatric Social Service.
   B. Character Handicap Work.
3. Personal (Medical) Division:
   A. Practical Psychiatry.
   B. Metric Psychiatry ("Mental Tests").

I suppose it would be superfluous to add that these divisions, though they correspond to experts developed and being developed, do not imply utter disjunction of material or technique. These experts are all dealing with melioristic aims and all use each other's evidence and technique.

It should also be redundant to say that any great further advance in mental hygiene and melioristics[4] hangs, like all advance in the past, on investigation and research.

CONCLUSIONS

It is proposed that the term *alienist* be used of experts in the forensic or medicolegal subdivision of mental hygiene, dealing with *insanity*.

It is proposed that the term *psychiatrist* be used of medical experts concerned with *mental diseases*.

As a minor point in nomenclature, it is proposed to distinguish the *alienistics* of a case from the *psychiatry* thereof. As insanity stands to mental disease, so alienistics would stand to psychiatry. Alienistics would be primarily a branch of law, psychiatry a branch of medicine.

Five or six subdivisions of mental hygiene are mentioned as existent or developing.

Public mental hygiene has the two well-established subdivisions, institutional and medicolegal.

Social mental hygiene has produced effective social service. It is a question how far character handicap work can go; but there are signs of a specialty in mental hygiene here also, using practical psychiatric, social-service and social-psychological categories.

Personal or *individual* (medical) mental hygiene is founded on the achievements of practical psychiatry which may now be regarded as a specialty independent of institutional mental hygiene and of "alienistics." But metric psychiatry is gaining ground, following the work of Binet, and "mental tests" promise to be of value not only in "mind-lack" and "mind-loss" questions of

practical psychiatry but also (at least negatively) in the field of character handicap work in employment and vocational choice.

REFERENCES

[1]Southard. A Key to the Practical Grouping of Mental Diseases. Transactions, American Neurological Association, 1917. Contains reasons, briefly stated, for the groups and sequence of groups mentioned in the text.

[2]Southard. The Major Divisions of Mental Hygiene: Public, Social, Individual. *Boston Medical and Surgical Journal*, Vol. CLXXV, No. 12, pp. 404-406, Sept. 21, 1916.

[3]Southard. Zones of Community Effort in Mental Hygiene. Proceedings, National Conference of Charities and Correction, Pittsburgh, 1917.

[4]Southard. Social Research in Public Institutions. Proceedings, National Conference of Charities and Correction, Indianapolis, 1916.

THE MENTAL HEALTH OF THE COMMUNITY AND THE WORK OF THE PSYCHIATRIC DISPENSARY*

C. MACFIE CAMPBELL, M.D.
Johns Hopkins Hospital

THE unfortunate patient, who suffers from one of the countless ills to which human flesh is heir, as a rule has insight into his condition and knows in a general way where to get help; even though unable to pay special fees he can go to a special clinic such as the eye clinic, or can consult the dispensary of the general hospital, where he is referred to the suitable special department. The nature of the work of each special department is familiar in its general outline to the man in the street.

The situation is somewhat different with regard to the department that deals with mental disorders; the public and even the medical profession are here not so well informed. The patient suffering from a mental disorder may have no inkling of his sickness; the family and social agencies frequently fail to realize that the situation is one demanding expert medical advice. It is important, therefore, to diffuse more widely the knowledge of what help is offered by a psychiatric dispensary, and of what type of cases should be brought there.

To many the name "psychiatric dispensary" suggests little or nothing; the term "mental clinic" or "mental out-patient department" sounds more familiar, and yet even so simple a term may call up in the minds of many a very misleading picture. Although living in the twentieth century, we are not free from the trammels of medieval thought. We are apt to deal with words, the symbols of reality, rather than with the facts of experience. So the term mental disorder, like the legal term insanity, has a certain ominous ring about it which makes people tend to avoid it.

It is well, therefore, to begin by freeing our minds from some general misconceptions before passing on to the presentation of concrete facts. Mental disorders are disorders of human adjustment, maladaptations, unhygienic compromises, immature or distorted methods of meeting the complex situations of life. The mental out-patient clinic or psychiatric dispensary deals with such

* Read before the Mental Hygiene section of the National Conference of Charities and Correction, Pittsburg, June 12, 1917.

disorders of adjustment; it deals with the failures of the individual to meet life's problems. Unlike internal medicine, psychiatry cannot limit itself to the failure of single organs or groups of organs to deal with their problems; it has to deal with the maladjustments of the personality as a whole. Psychiatry may therefore be considered as personal medicine, as opposed to impersonal medicine; while in other departments the personality may be ignored, although not always with impunity, in the mental clinic the personality is the organic unit with which we work. It is true that disorders of the individual organs and of groups of organs may cause modifications of the personality. The personality is not something outside of and apart from the constituent organs of the body; it is the total activity of these organs more adequately conceived. The study of the personality and its disorders involves the study of all the bodily organs, but in a more complete setting than is necessary in internal medicine.

In the mental clinic, therefore, we deal with patients whose symptoms require for their understanding a study of the personality and of its problems. Mental disorders are not disorders whose symptoms necessarily are mental, but whose *roots* are mental, that is whose roots cannot be understood without studying the patient in his complete human relations. The symptoms may be insomnia, or headache, or vomiting; they may consist of a paralysis or a tremor; they may be limited to an apparent blindness or deafness or dumbness; and yet the disorder may be a mental disorder because its roots lie in the difficulty the personality has in its adjustment to the situation. The personality, in the face of difficulties, may find refuge in phantasies, deliria or hallucinations, but also in aches and pains and palsies, and the latter may be as truly evidence of mental disorder as the former.

Symptoms such as paralysis or blindness may be the signal of a complex human difficulty while the individual organs are sound; on the other hand changes of personality, moods, hallucinations and delusions may be the sign of the disorder of some individual organ or group of organs. The organs involved may be the central nervous system, the glands which are at the very basis of the emotional life, or some other organ such as the stomach, or lungs. Where the personality is involved in this secondary way the mental symptoms are merely symptomatic of disorders, the study and treatment of which can be carried on along the narrower lines of internal medicine.

A survey of the actual work done in the psychiatric dispensary may begin properly with the children; these may be divided conveniently into the subnormal and the neurotic group.

With regard to the former group, the early recognition and complete study of any constitutional defect is extremely important; this enables the physician to advise the teacher, to guide the mother, to safeguard the child from deleterious influences, from drifting into unhealthy or delinquent habits, from becoming the tool of the unscrupulous. Pronounced backwardness at school without obvious cause is a sufficient indication that a psychiatric examination is required.

The neurotic group is composed of those children who show such symptoms as night-terrors, bed-wetting, tantrums of temper, excessively fidgety behavior, poor sexual habits, pilfering, romancing, unexplained moods, marked cruelty or other anomalous traits of character.

In every case the physician aims first at a thorough study of the child from the point of view of his physique, his intelligence, his emotional life and general balance; and then at a study of the influence of the environment on the formation of habits of the child. With the teacher he discusses the school situation; with the parent he has to review carefully the home behavior of the child, the development of the neurotic traits, and the conditions which may influence them. The individual child thus may get help, symptoms be relieved, improper habits checked; but an important by-product is that the teacher gains a broader conception of the nature of education, the parent a deeper insight into the problem of training the child—a task often so honestly taken up and so inefficiently carried out.

In order that the teacher may furnish essential data to the dispensary physician, the latter should supply simple forms in which the important facts can be briefly entered; the teacher may then learn to fill in such a form, not as a burdensome routine duty but with the same interest with which the physician makes his notes. Similar co-operation should be obtained from all social workers dealing with the problems of childhood, when they bring one of their wards to the dispensary for examination. This of course applies equally where the ward is a child, a wayward adult, or delinquent, or drug addict. The social worker should realize the importance of a psychiatric opinion on such cases, and should prepare the available data with some insight into the require-

ments of the physician; while the latter, in the light of these data and the examination of the individual, should be prepared to furnish the worker an opinion, which will make the actual management of the case more efficient. Such work will be a source of instruction to the individual worker; it will make less haphazard and more firmly based on rational principles the work of many organizations dealing with prisoners, unmarried mothers, juvenile delinquents, and dependents of other types. Work of this type will do much to instruct the whole community as to the underlying causes of these disorders of conduct and the necessity of dealing with them at an early stage, that is, in the school period.

The adult patients of the dispensary present a great variety of practical problems. Sometimes the problems are those of the general dispensary; that is especially true where the mental symptoms point to some underlying disease, either of the central nervous system (*e. g.*, brain tumor) or of some other organ or group of organs (*e. g.*, exophthalmic goitre). But in a large group of cases the symptoms are intimately associated with personal difficulties of adjustment, and a thorough study has to be made of the whole attitude and balance of the patient, and of the life-situation in which he finds himself.

A painstaking review and discussion of those factors, which make for happiness or unhappiness in life, is often a relief and revelation to patients, whose ailments have hitherto been treated in the traditional impersonal way by drugs, rest-cures, and operative measures.

Thus a young man came prepared to enter the hospital for the treatment of persistent headache; the headache was associated with worry over faulty sexual habits. A frank discussion of the whole situation relieved his mind considerably; he was encouraged to improve his adaptation outside rather than to take refuge in the hospital. Accordingly, a somewhat uncongenial environment was given up for residence in town, suitable employment was found, the patient took up the regular gymnasium work of the Y. M. C. A. along with other recreation in the evening. Since then the patient's attitude toward life has been transformed from one of sensitive seclusiveness to a much more healthy outlook; instinctive control is satisfactory; headache is no longer spontaneously referred to, while his improvement has been an enormous relief to his family. Encouraged by the improvement of the patient, a brother has also sought advice.

While the aim of the treatment is the readjustment of the patient to the environment, the method is largely re-educational; at the same time, such general measures as drugs, diet and baths are not neglected. Re-education of the patient means that he studies his own personal difficulties in a rather intensive way (assuming he has the requisite intelligence); he traces out the factors which have influenced his habits and attitudes; he learns to face the facts of his life in their biological crudity as well as in their ethical and aesthetic setting; he gains courage to discard mental makeshifts and disguises.

But this gain in honest insight into the problems of life must not be a barren intellectual exercise; it must go hand in hand with a search for those practical aids to the formation of better habits which the community may offer, and must be accompanied by the actual utilization of these aids. In the daily and weekly program the varied needs of human nature must get sufficient recognition; work should yield its own return, opportunities for recreation should be available, the social, intellectual, aesthetic and religious aspects of life must not be ignored; balancing factors in the way of hobbies are to be encouraged, and the fundamental relations of the patient to his own family are of cardinal importance. While the physician with his special knowledge helps the patient to unravel his tangles, the trained social service worker plays an essential rôle in directing the first steps of the patient. It is the aim of this communication to outline this work and illustrate it.

A girl of twenty-one with a slight physical deformity took it very seriously to heart, saw her life as without any promise, and harped on a number of physical complaints which seemed to have no adequate cause. A review of her case showed that, partly owing to personal difficulties, partly owing to faulty training and difficult circumstances, she had developed her invalidism as a protection, while her true interests found no outlet. Frequent interviews with the physician enabled her to adopt the latter's attitude toward her symptoms. At the same time the social service worker* got in touch with the patient's sister, and did much to correct the attitude of the latter, who had fostered the patient's invalidism. She put the patient in the way of developing her artistic talents by arranging for an exceptional educational op-

* I take this opportunity to express my indebtedness to Miss S. L. Lyons, in charge of the Social Service Department of the Psychiatric Dispensary, for her assistance in the preparation of this paper.

portunity. The patient was soon able to discard her protective invalidism; she has made a good start on the road to economic independence; her attitude toward life is one of cheerfulness and hope instead of discouragement and resignation, while the slight physical deformity has shrunk in her perspective from a mountain to a molehill, and as a matter of fact is not noticed by her comrades. The fact that the patient was referred to the dispensary by the physician who was consulted for the physical deformity, illustrates the benefit of the medical profession in general being trained to recognize such disorders, which are so apt to masquerade in disguise.

The general social worker, too, does well to respond with some sensitiveness to anomalies of personality, and to know when to invite a psychiatric opinion before planning the life of the individual. A young woman of eighteen, with some artistic talent and superficially bright, enlisted the sympathy of a district social service worker through her story of ill-treatment at home. The latter obtained for the girl the opportunity of going to town to take up the study of art. The girl soon attracted the attention of her companions by her phantastic stories and lack of responsibility and she was brought to the psychiatric dispensary for examination. A thorough review of her condition and of her early development showed that she was constitutionally inferior, not in the sense of being intellectually defective, but in her response to ethical standards. This condition of constitutional psychopathic inferiority, which gives rise to so many legal and other difficulties, made it necessary in view of her actual behavior to have her placed in a state hospital. The well-meant endeavor of the social worker to help the patient went astray, because the former was guided rather by sentimental considerations than by trained insight into the personality of the patient. The contact of the general social worker with the psychiatric dispensary should broaden the basis of much social work and be one more step in diffusing knowledge of mental hygiene throughout the community.

The consistent and conscientious treatment of the patient means that whatever necessary conditions are indicated for the readjustment of the patient should, if possible, be placed at the patient's disposal, although the search for them takes one from the hospital into the school, the labor market, and the church. The concrete needs of the individual patient have to be defined

and supplied; by that we do not mean that the situation is made too easy for the patient, nor that the patient is encouraged to become dependent on the support of the clinic. But the patient must be given more than general directions, must at first be led, perhaps, until the way is more familiar.

To make the steps and nature of the treatment clear, further individual cases may be quoted. A woman of twenty-six for several years had complained of severe headache, dizziness, vomiting, burning pains, insomnia and nervous feelings; the physician who had treated her by the usual medical measures for a long period without result, recognized the true nature of the case and transferred her to the psychiatric dispensary. The mental roots of the disorder were not difficult to discover, and the mental hygiene of the patient was placed on a better basis. She was sensitive about her ignorance of English; she got little satisfaction from her few household duties; she squandered much time and energy in day-dreaming.

Under the stimulus of the social worker, she was encouraged to take systematic lessons in English; she became a member of a gymnasium class at the Public Athletic League; she joined the swimming class; she learned to develop her home responsibilities, attended the weekly occupation class at the psychiatric dispensary, and did some volunteer social service work. When the patient first came under observation her condition was such that admission to a state hospital was seriously considered and would have been welcomed by the husband. With the help of the measures outlined above the patient improved greatly, although leaning frequently on the social service worker. The husband was much encouraged by the improvement; his hearty co-operation in the treatment was the result of the support by the clinic, and replaced his previous resignation to the prospect of having her leave home for a long residence in a hospital.

It is often so; with the dispensary to fall back on in time of need, the husband or wife, parent or child, is often much more willing to undertake the task of looking after the patient at home.

The treatment of the patient is the treatment of the whole situation and the other members of the family must often receive psychiatric attention, as in the following case.

A man of forty-seven, with epileptiform convulsions, was suspected of malingering by the social organization which helped to support his family. Examination at the psychiatric dispensary

determined the organic nature of the disorder; he was operated on in the hospital, unfortunately without relief; after leaving the hospital he continued to visit the psychiatric dispensary where he attended the weekly occupation class, his sole recreation. His wife preferred to care for him at home than to have him admitted to a state hospital. It was found that two of his children showed neurotic symptoms; they were accordingly examined, their mother was advised as to the necessary home hygiene, their school teachers were interviewed and informed of the medical opinion, gymnasium privileges were arranged for and the necessary shoes provided.

The range of the work done by the dispensary in treating adequately the situation presented by a patient is shown in the following case. A foreigner, cultured but eccentric, was referred to the dispensary from the tuberculosis clinic on account of his depressed condition; his funds were low, there had been friction with the church authorities, the fault not being altogether on his side. In view of his prejudices and somewhat difficult personality, the problem of readjustment was rather complicated. The friction with the church authorities was smoothed over, a suitable position was obtained for the patient, debts were paid in order to let him move from a quite uncongenial environment to one more suitable for him and for his children, clothing was provided for the family, artificial teeth for the wife, some literature was put at the patient's disposal, and the basis for some congenial friendships was laid. Such a series of steps may seem to stretch rather far the function of the dispensary, but so long as the therapeutic problem is taken seriously they are as essential as the individual steps in surgical or ordinary medical treatment.

From the economic standpoint the outlay in such a case comes up for scrutiny. The serious probability was that this eccentric man, with his cultural interests starved in a drab environment, unable to earn his living owing to the church friction, would show progressive embitterment and develop definite delusions. The result would then have been his admission to a state hospital, perhaps to remain for life, while his children became a charge on the community. By the measures taken, which involved an expenditure of less than two hundred dollars, he promises to become a productive economic unit, the support of the family, getting satisfaction out of life, an asset to the culture of the community. Not only is he himself happy, but the prospects for the

healthy development of his children are infinitely better. This is preventive medicine.

Even in cases where the seriousness of the disorder allows only palliative treatment, the dispensary can do much to outline measures to reduce friction with the patient; the physician, by giving the family an insight into the medical view of the disorder, may rob it of much of its bitterness.

One important practical decision has frequently to be made, namely, whether the patient should be placed in a hospital even without his co-operation. The relatives are apt to take the symptoms merely at their face value; the physician, however, realizes that a patient with incipient paresis may seriously compromise his name and fortune, that a patient with a mild depression may commit suicide, that a seclusive and embittered patient may suddenly commit a homicide. Impressed with these dangers he may urge the friends of the patient to take the necessary steps to have the latter admitted to a state hospital or private sanatorium. In the popular mind old associations still cling to the hospital for mental disorders; the man in the street hardly realizes that they are hospitals in the true sense of the word, specially staffed and equipped for the curative and palliative treatment of disease.

One need not blame the man in the street, for physicians and social workers often require enlightenment on this topic. In illustration, I may quote an extract from the letter of a social worker, protesting against the advice to send a young woman to a state hospital:

"From a physician's point of view, would you advise further hospital treatment outside of an insane asylum? So long as she is perfectly harmless, would she stand a better chance in a medical hospital for a little while longer, if we could so place her?" This reference to a state hospital as an insane asylum, a place which is not regarded as a medical hospital but where patients should be sent only when they cease to be harmless and can not be benefited by further treatment, illustrates a medieval trend from which contemporary thought must be purged. Where the medieval attitude still dominates the institutions of the state, it is an imperative duty of the community to see that the hospitals are brought up to a modern level.

It is not sufficient to give to the family the summary advice that commitment to a state hospital is necessary; the nature of the

advice must be made clear, any prejudices removed so far as possible, the actual steps for the admission of the patient arranged with the utmost consideration for the attitude of the patient. The relation between the patient and the physician in the state hospital may be seriously compromised by injudicious management of the patient before admission; there should be no deceit; non-medical interference, such as the co-operation of the police, should be avoided except in a serious emergency, and then a plain-clothes man should be employed.

A frank attitude towards the patient may gain co-operation, even where the outlook is not promising. Thus a woman of forty-two at first rejected indignantly the advice to go to a state hospital; she had ideas of persecution, thought that she was followed by detectives, threatened to shoot her persecutor, and was incensed at the physician's guarded suggestion that her whole attitude required a detailed examination such as could only be adequately carried out in a special hospital. After two months' contact with the dispensary, she herself asked the physician to make the necessary arrangements for her admission to the state hospital. After a stay of over a year in the hospital she left it and visited the dispensary; she still clung to her old ideas and did not accept the physician's view of her sickness, but she had no resentment against him for having sent her for treatment to a mental hospital. Some months later, unable to establish herself in the community, she returned voluntarily to the state hospital.

The detailed treatment of the individual case, so far as the analysis of the symptoms and the readjustment of the patient's attitude are concerned, belongs more to a technical medical discussion than to the present review, which aims more at a discussion of the objective methods involving social co-operation. It may be helpful to mention briefly those social organizations with which the psychiatric dispensary must keep in touch, through its social service department. To a large extent they supply the machinery for the readjustment of the patient, and the problem of the psychiatric social service worker is largely to co-ordinate their individual services. Contact with these organizations to be efficient must be personal and intimate, not formal and perfunctory.

The dispensary must be in close touch with the school system and co-operate with principals and teachers, so that their problems are freely referred to the dispensary, and its advice actually carried

into practice. Similar relations should exist with the juvenile court, with reform and parental schools, and with all official charity organizations, for no organization can deal adequately with the problems of dependency which does not realize the rôle played by mental defect or disorder. These organizations can not only bring their problems to the dispensary, but make a valuable social apparatus available for the readjustment of the psychiatric patient.

Such readjustment is often facilitated when the psychiatric worker is in touch with the large employers of labor and with employment bureaus, such as the new Federal Employment Bureau; the economic readjustment is often an essential part of the total task.

For the development of those human interests which are such important balancing factors in life, one must be in touch with the local opportunities for promoting self-culture, with organizations such as the night schools, the Jewish Educational Alliance, the Y. M. C. A. and the Y. W. C. A. The patient may also be grateful for some help in utilizing the other cultural opportunities of the community, the museums, libraries, picture-galleries and concerts. Simple recreative opportunities are sometimes to be found in well-run municipal dance-halls, while the humble "movies" may be recommended as an invaluable diversion in a community where the only alternative is the saloon.

For physical culture, the development of the *corpus sanum* as a fit temple for the ideal *mens sana*, one must be able to utilize the gymnasia associated with the above organizations, with several churches, with the Public Athletic League, while in summer healthy exercise and recreative diversion are combined in summer camps, perhaps under the auspices of the Boy Scouts or the Camp Fire Girls.

Where the patient has not cut himself adrift from his organic church affiliations, it is important that this most potent influence in human life should play its rôle in the readjustment or hygienic resurrection of the individual. This is to be done not by referring the patient to some hybrid organization, a blend of church and medicine, but by restoring the patient to the fellowship of that church of which he was an organic member; with his fellow-members he is entitled to get from his spiritual guide some practical help in harmonizing his highest needs with the other insistent demands of human nature. Co-operation of this type will be

more generally available when those preparing to be the spiritual leaders in the community are offered, during their training, a psychology that deals with the actual conflicts of the home and the market, and not a sterilized laboratory psychology.

Here may well end our brief sketch of the organic connections of the psychiatric dispensary with the life of the community, and of the task of those who help us in building up again the structure of human lives which have been badly shaken.

"And difficult as it may be to transform the instincts that dwell in the soul, it is well that those who build not should be made aware of the joy that the others experience as they incessantly pile stone upon stone. Their thoughts and attachments, and love; their convictions, deceptions and even their doubts—all stand in good service; and when the passing storm has demolished their mansion, they build once again with the ruins, a little distance away, something less stately perhaps, but better adapted to all the requirements of life."

SUMMARY

Indigestion and headache may be mental disorders just as truly as are morbid phantasies and distorted attitudes; it depends on their origin.

The mental out-patient department or psychiatric dispensary of a hospital deals with symptoms of mental origin, whether the symptoms are called physical or mental.

The psychiatric dispensary will be of the greatest value to the community when physicians and social workers who come into contact with cases of mental disorder or defect know the type of work done there.

The teacher who promptly secures a psychiatric opinion on her subnormal and neurotic pupils, develops deeper insight into her own special educational task.

The basis of much philanthropic work can be broadened if the psychiatric dispensary is freely consulted by workers dealing with the dependents on society, delinquents, prisoners, vagrants, drug addicts, unmarried mothers, etc.

Many patients with mental symptoms have somatic disorders and present no different problems from those met in the general dispensary. Other patients do not react to the ordinary medical treatment (drugs, baths, exercise, rest, operation, etc.) because the symptoms are interwoven with the personal difficulties of the

patient. The psychiatric dispensary, receiving these patients from the general dispensary or from outside physicians, helps to keep before the medical profession the importance of certain factors of health too often neglected, namely those factors which are the special province of mental hygiene.

The treatment of a patient often means his re-education, his revaluation of the various factors in life, his progress from an immature attitude to one more mature and honest. Difficulties in the life-situation of the patient which are open to modification must not be neglected. At the same time, more hygienic adaptation to the complex demands of life, the formation of better social habits, are complex tasks where supervision by an intelligent social service worker is invaluable.

The social service worker, to be of practical use to the patients, must keep in intimate personal touch with many aspects of the community life, economic, educational, philanthropic, religious and recreative.

The treatment of a patient frequently means the treatment of his whole domestic and economic situation; the thorough performance of this task is to be considered preventive medicine.

FEEBLEMINDEDNESS AND DELINQUENCY

J. E. WALLACE WALLIN
Psycho-Educational Clinic, St. Louis

DURING the last few years it has been repeatedly affirmed that "every feebleminded child is a potential criminal" and that "the majority of criminals are mentally defective." These claims have been buttressed by figures purporting to show that from 50 per cent to 85 per cent and even 90 per cent of different groups of delinquents and criminals have actually proved upon examination to be feebleminded. So far as it is possible to judge from the scanty data that have been supplied in the publications (we have summarized most of the recent studies on pages 123 to 190 of the *Problems of Subnormality*), it is apparent that the examinations made in many of these studies have consisted solely of a Binet-Simon test, and the diagnoses have been based upon certain arbitrary, quantitative standards of intelligence deficiency. The surveys have almost invariably been based on selected groups of offenders, juvenile delinquents (so-called) found in juvenile courts, detention homes, and "industrial" or "training" schools, juvenile and adult prostitutes found in homes and in institutions, and juvenile and adult criminals found in jails, reformatories, and penitentiaries. Some of the adults have been 70 or 80 years of age and have undoubtedly presented various degrees of deterioration and dementia. Sometimes the person who has prepared the contribution and made the diagnoses has not examined, nor even seen, any of the cases diagnosed.

A survey of the literature on the relation of feeblemindedness to crime and delinquency reveals clearly the fact that the studies which have been made by examiners who are cautious and of sober judgment and who have brought to the work a wide experience with the feebleminded and an intimate knowledge of feeblemindedness, have yielded estimates very much more modest, usually falling below 25 per cent or 30 per cent. In fact, some of the trained examiners report only from 5 per cent to 10 per cent or 11 per cent of feebleminded cases among the delinquents whom they have examined.

Practically all of the clinics thus far established have been instituted primarily for the examination of feebleminded and backward children, and sometimes also for the children whose

deportment is defective. It has seemed to the writer, however, that no better opportunity exists for the study of the relation of mental deficiency to social misconduct than is afforded by a psychological clinic connected with a large public school system. If the tendency toward misconduct, truancy, delinquency and crime is especially characteristic of feebleminded children, we should expect to find an excessively large percentage of feebleminded children among the pupils reported as difficult to manage, troublesome, truant, delinquent, thieving, vicious, or immorally or criminally inclined.

In the course of the last three years we have examined 1,363 different cases* in the psycho-educational clinic conducted by the Board of Education of the City of St. Louis. This clinic was established primarily for the examination of candidates for the special classes for mental defectives. Owing to the inadequacy of the clinic staff it has been necessary to limit the examinations largely to such cases, although principals have been permitted to refer disciplinary pupils for examination, even though they did not consider them to be feebleminded. But at times we have had so many cases that we have not been able to examine disciplinary children unless they seemed proper candidates for a special school for the mentally deficient. We have, however, made an exception of the truant boys assigned to the "Boys' Class," and almost all of them have been examined.

It is evident from these facts that the proportion of feebleminded children that we find among our disciplinary cases does not represent the proportion of feeblemindedness that would be found among all the disciplinary pupils in the entire school system. Under our procedure the brightest among the misbehaving pupils would not come before the clinic at all, or only rarely. Our percentages, therefore, could apply only to groups of troublesome children who are also mentally inferior. The peculiar value, then, of our data, does not consist in the light which they throw upon the question of the prevalence of feeblemindedness among delinquent and offending youths in general, but in the opportunity which they afford of determining whether the percentage of feeblemindedness is greater among the backward pupils who have a record of delinquency than among the

*This does not include children examined in connection with baby clinics, or "better babies" contests, or children privately examined. Pupils re-examined in the school clinic have been counted only once.

backward pupils having no such record. In other words, we are able to compare two groups of pupils that are quite similar in that the children are examined primarily because of inability to do their school work or because of suspected mental deficiency, but which differ in that one group has shown delinquent tendencies while the other has not.

Of the 1,363 cases examined, 248 had a delinquent record. The delinquencies included the following: disorderly, unruly or troublesome conduct in school, truancy, lying, stealing, viciousness and immoral practices or tendencies. Most of the pupils were boys. Many of the boys had been sent to the Boy's Class for truants, many were wards of the juvenile court, while some of them had been committed to the industrial school (residential). We shall refer to them indifferently as delinquents or disciplinary cases. The details regarding the 173 delinquents examined during the school years 1914–1915 and 1915–1916 will be found in *Problems of Subnormality** which gives the data for the boys and girls separately, the amount of intelligence retardation, and the intelligence quotients. The details for the 75 delinquents examined in 1916–1917 are given in the report of the Psycho-Educational Clinic and Special Schools, in the Report of the Board of Education of the City of St. Louis for 1916–1917.

All of the psychological examinations and intelligence diagnoses were made by the same person, using the same tests and standards of diagnosis, thus eliminating the variations due to the personal equation. The physical examinations were made by the regular inspectors of hygiene, who also recorded the personal and family history, while the school staff supplied the pedagogical data. Our space here permits us to call attention only to the facts contained in Tables I and II.

In Table I we have separated the 864 examinees into two groups, those in one group being reported by the school staff for delinquent conduct of some kind, while those in the other group were not so reported. It is possible that some of the pupils in the non-delinquent group were also inclined toward some kind of misconduct, although they were not so reported. Ordinarily, however, if a child is unruly or delinquent this fact is emphasized in the reports sent to the clinic. It is seen from the table that the proportion of normal children and those only a little below normal (called "retarded") is slightly higher among the delinquents than

*Pp. 181–185, and 242–248.

Table I

Diagnosis of 173 Delinquent and 691 Non-Delinquent St. Louis Pupils Examined from 1914 to 1916

	Non-delinquent per cent	Delinquent per cent	Difference per cent
Normal	5.0	6.9	+ 1.9
Retarded	7.3	9.2	+ 1.9
Backward	34.1	49.7	+15.6
Borderline	12.3	11.5	− 0.8
Deferred	7.8	1.7	− 6.1
Mentality undetermined	0.7	0.0	− 0.7
Morons	17.0	15.0	− 2.0
Imbeciles	14.7	5.7	− 9.0
Idiots	0.7	0.0	− 0.7
Total feebleminded	32.4	20.7	−11.7

The + sign indicates a larger proportion among the delinquents than among the non-delinquents, while the − sign signifies the opposite.

among the non-delinquents. On the other hand, the proportion of morons is somewhat smaller and the proportion of imbeciles distinctly smaller among the delinquents than among the non-delinquents. The percentage of feebleminded among the delinquents is almost 12 per cent less than among the non-delinquents. The largest difference of all is in the backward category. The percentage of backward children is distinctly higher among the delinquents than among the non-delinquents, the difference amounting to 15.6 per cent.

The same general facts appear in Table II, in which, however, the figures in the first column are based on the total number of cases examined in 1916–1917, including the 75 delinquent cases

Table II

Diagnosis of 499 St. Louis Pupils Examined in 1916–1917

	Total number per cent	Delinquent per cent	Difference per cent
Normal	3.0	9.4	+ 6.4
Retarded	4.6	6.6	+ 2.0
Backward	32.8	48.0	+15.2
Borderline	31.2	22.6	− 8.6
Deferred	5.2	5.3	+ .1
Mentality undetermined	0.2	0.0	− 0.2
Morons	12.0	4.0	− 8.0
Imbeciles	10.4	4.0	− 6.4
Idiots	0.4	0.0	− 0.4
Total feebleminded	22.8	8.0	−14.8

already mentioned, but excluding children who had been examined during the two preceding years and a number of non-school cases. Had the delinquents been eliminated from this column, the differences which appear would have been slightly larger.

There are appreciably more normal children and children only slightly below normal among the delinquents, while the proportion of borderline, morons and imbeciles is distinctly smaller among the delinquents. The proportion of feebleminded children is almost 15 per cent less, while the proportion of backward children is a little over 15 per cent higher among the delinquents than among the total number of pupils examined.

On the basis of the analysis of our St. Louis data for the years 1914–1915 and 1915–1916, and on the basis of earlier studies and observations which we have made respecting the relation of mental deficiency and delinquency, we have previously reached these conclusions:

"It is particularly the backward pupil (instead of the feebleminded one) who creates the problems of discipline in the schools," just as it is "the borderline (and backward) cases which cause the most trouble in the institutions, 90 per cent of the disciplinary troubles being attributed to them. . . . The slow, backward child is, I believe, a more aggressive and intelligent trouble maker, and constitutes potentially a greater criminal menace. . . . We do not wish to imply that the feebleminded pupils are entirely tractable and cause no disciplinary troubles. Many of them are exceedingly restless, mischievous, and prone to outbreaks of temper, while some are consummate plotters of evil. And yet, it is probably true that most of the feebleminded develop delinquent tendencies in after years, not so much because of outspoken vicious proclivities as because of intellectual and moral weaknesses, weak powers of inhibition, and inability to resist temptation. They often become unsuspecting, helpless, or guileless dupes of the more intelligent vultures who prey upon the weak. The feebleminded as a class become a social menace because of their weaknesses and because of environmental opportunities. . . . We believe that a large number of criminals and prostitutes now diagnosed as feebleminded really belong in our class of dull, backward individuals."*

The conclusion that we have reached on further study of the problem during the past year is in harmony with the above state-

*Problems of Subnormality, pp. 248–250.

ments. We realize, of course, that some feebleminded persons who are non-delinquent in youth will become delinquent in later life. But this is also true of the borderline and the backward cases; but whether they will be in greater or less measure is a problem for future determination from follow-up work under various conditions with feebleminded, borderline, and backward children.

ILLEGITIMACY AND FEEBLEMINDEDNESS*

J. PRENTICE MURPHY
General Secretary, Boston Children's Aid Society

MATERNITY represents the most continuously exacting individual responsibility known to society. As community standards have been raised, they have always been preceded by the raising of the standards of maternity care, for every other standard in the community is affected by the care and training which the mother gives to her child.

The married woman living under normal conditions—and these involve the protection of a husband, a good home, proper physical care, sufficient food, adequate social life, education, normal opportunities for self-expression and for recreation—still has a most exacting responsibility in the rearing and training of her children. No protection she can possibly receive detracts one iota from the respect and admiration due to her for the great personal service she renders to her family and the state when she gives intelligent care to her children. And this picture of the true mother is a constant ideal through all civilized society.

The protection and approval which we as individuals in society give to the married mother as she performs her sacred duty are in marked contrast to the pains, privations and degradations visited upon the woman who gives birth to a baby out of wedlock, the woman whose baby's father is often unknown, whose child starts life without, as we term it, the essential and basic protection of home and family, of respect in the community, of a reasonable chance for a normal development.

No more striking picture of the unmarried mother occurs to me than the description by Dr. Leffingwell: "Against the background of history, too prominent to escape the observance from which it shrinks, stands a figure, mute, mournful, and indescribably sad. It is a girl holding in her arms the blessing and burden of motherhood, but in whose face one finds no trace of maternal joy or pride. There is scarcely a great writer of fiction who has not somewhere introduced this figure into the shifting panorama of romance, appealing for pity to a world which never fails in compassion with imaginary woes; now it is Effie Deans in the

*Read before the Conference on Feeblemindedness of the Massachusetts Society for Mental Hygiene, Ford Hall, Boston, Dec. 14, 1916.

Heart of Midlothian; now Fantine resting by the roadside with Cosette in her arms; or Hester Prynne pressing little Pearl against the scarlet letter as she listens from the pillory to the sermon of Dr. Dimmesdale. Who is this woman, so pitiable yet so scorned? It is the mother of the illegitimate child. By forbidden paths she has attained the grace of maternity, but its glory is for her transfigured into a badge of unutterable shame."

Yet the tragedy of this frequently unprotected, unmarried mother and her baby is as nothing to the sordid and utterly discouraging spectacle of the mother who, in addition to being unmarried, is also sick in mind, impaired mentally, a defective.

Each year an increasing number of unmarried mothers come to the organization with which I am associated. During the past year almost 300 came to us, or more than one-third of all the unmarried mothers reported in one year for the city of Boston. It is our problem to assist with all the means the community offers in helping these mothers as befits their individual needs. This is no easy task. Society in its efforts to protect the family and the individuals within the family inflicts a terrible penalty on those who bring children into the world out of wedlock, a penalty which even in this day of multiform kindness and sympathy is heavy, and one from which the individual tries in every way to escape.

I do not wish to dwell at length on the costs to the mentally normal unmarried mother, but I do wish to show how difficult it is to help her in the face of this widespread prejudice. She usually must leave her family because they share her desire for secrecy, and in going elsewhere she is most often forced to accept fewer protections and in consequence her standard of living is lowered. To all the physical and mental strain of a normal pregnancy which the married woman has to endure, there is added the terrible anxiety due to loneliness, homesickness, loss of social position, the strain of living under new and strange conditions, and beginning all over again in an untried field, giving up the old things to which one has become accustomed and which are part of one's life and in which one is proficient, to take up new things, often menial and which carry with them a certain social disapproval. To the physical strain is often added under-feeding, improper housing, the interruption of a normal recreational social life and disarrangement of the essential little things that fill and round out every well-ordered life. There is the lack of

protection of husband and home and family and friends and old associations, and all this bears heavily on personal and vital resources. If she is gifted with great personal courage, if she is spiritually minded, she may plan to meet all these burdens bravely and fearlessly; or, before she has time to reason a way out of her terrible plight, she may have tapped the sources of some organization which persuades or forces a plan which otherwise she would never have had the courage or the fortitude or the forethought to work out for herself.

Last year the Federal Children's Bureau in making a study of illegitimacy in Boston found that according to the records kept by the Bureau of Vital Statistics, there were approximately 800 illegitimate births for the year, and of this total number approximately one half were unknown to all the public and private charity organizations in the city. These unknown mothers, representing undoubtedly every condition, made their own plans which involved in most instances the placing of the babies apart from the mothers, frequently for adoption, and often under conditions which would not bear the searching light of careful inquiry. Many of these mothers returned to their own people with the fact of their maternity supposedly known only to a few—I say supposedly, for we delude ourselves into thinking that anything so important, so fundamentally pervading as the creation of life, can be suppressed and effectually concealed. A certain number of mothers of low mentality were still successful in making their own plans and have gone back unprotected to the communities from which they came, their mother responsibilities being over for the present.

The normal, unmarried mothers who come to us, or to any other organization, face a task of adjustment involving truly enormous responsibilities, and we never cease to marvel at what they have to endure and what they do—that is, the mothers who express personal responsibility for the babies to whom they have given birth. Nothing that we may do ever makes their task easy; much that we do often makes their task bearable.

Each normal, unmarried mother calls for flexibility of treatment. It may be possible to arrange for her return to her family or relatives. More frequently it means arranging for care with strangers. If she is unskilled, she may go into a family with her baby, or she may work in one family and have her baby cared for in another. If she is skilled, she may go back to the office or

factory, boarding her baby. Most generally, we are finding the best results where the mothers work apart from their babies. They cannot otherwise meet the competition of other working women who are unburdened with babies and children, certainly unburdened with the responsibilities of their immediate care. Moreover, even in the field of family service, the number of homes open to mothers with their babies are few, and unless great care is exercised, the mothers who are selling their labor and must for a certain wage deliver a certain service, will be forced to give less than the necessary amount of time and attention to the well-being of their children.

Now, all we plan for the normal unmarried mother is of little value for the feebleminded mothers. The feebleminded mother presents a picture with varying lights; briefly, as follows:

Rarely is there anything sacred or elevating in the relationship with her baby's father. The feebleminded mother is usually unable to say just who is the father of her baby. Her association with men has been entirely promiscuous, not a matter of long planning or accompanied by romance, but just a straight, sordid expression of the animal. Legal action for support where the mother is feebleminded is generally impossible to carry through in the courts and wisely so, because the feebleminded girl cannot say with any certainty just whom she has lived with. A child born to a feebleminded mother under the best conditions is under a cloud, and when the mother, as is usually the case, must seek shelter in a place other than her home, the ensuing neglect which she suffers and passes on to her child accentuates whatever mental deficiencies the child may have. The height of human woe cannot well exceed the state of a child, who, born as illegitimate, is also born to a feebleminded mother who cannot even protect herself.

The feebleminded mother does not learn by experience. In a group of 184 normal, unmarried mothers, there were 186 children. The normal girl does not easily forget the horrifying ordeal through which she has passed. In a group of 38 feebleminded mothers, there were 46 children. We have knowledge of feebleminded mothers who have had two, three, four, five, and six children each. The following are some typical instances of feebleminded women who have had children:

A. F., German, 38 years old, has borne one child, feebleminded.

M. D., American, 33 years old, one child.

M. P., American, 18 years old, tried to commit suicide; has given birth to one child and is again pregnant.

R. K., German-American, 26 years old, two children.

M. F., American, 27 years old, has had one miscarriage and has given birth to a baby.

M. S., American, 19 years old, one child.

N. S., Jewish-American, 27 years old, one child.

E. F., American, 21 years old, one child.

L. S., colored, 35 years old, unmarried, has given birth to eight children, some still-born, some with operations, all by different fathers.

M. B., 24 years old, herself illegitimate, two children by different fathers.

T. S., 32 years old, American, sexual pervert, has borne four children by four fathers.

B. G., 21 years old, American, has given birth to one child which she repeatedly drugged to lessen amount of care required.

The feebleminded mother is not necessarily more sex-assertive than the normal mother, but she is certainly less qualified to protect herself. Many of the defective mothers who come to us are not over-sexed, but they have no comprehension of the significance of the maternal feeling. They often have, however, a skilful veneer that passes for deep maternal feeling which deceives repeatedly all but the keenest observers. It is this type of girl, diagnosed as feebleminded by the psychiatrist, who is nevertheless successful in her appeal when her case goes to court. Her care-free, girlish, surface attractions cover the shallow emptiness of her defective mind. The courts are still most conservative about taking cognizance of the irresponsible social acts of the feebleminded mother who in her appearance seemingly belies such acts. This is a great obstacle in treatment which the courts and social agencies must work out.

With many feebleminded mothers the maternal feeling is exceedingly strong and there goes a love for babies and children, and this is a snare which often entraps a man deserving a higher type of companion. I refer now specifically to a group of feebleminded girls who have had illegitimate children, often feebleminded, and who have subsequently married and now continue under the sanction of the law to rear other unfit children.

The feebleminded mother suffers frequently from syphilis or gonorrhea and because of her mental condition is unable to protect

her child from infection. We are in touch at this moment with one defective mother suffering from gonorrhea whose child likewise has gonorrhea, the child's infection coming from the mother.

The feebleminded mother is unable to profit from the assistance and care which are of help to the normal, unmarried mother. Every public and private organization caring for defective mothers in the community is continuing with an expense out of all proportion to the results obtained.

The feebleminded mother with her baby or babies is in home after home an impoverishing drain and expense. Feeblemindedness often arises in families of normal parents, being due to causes which they cannot control. When to the burden in a poor home of a non-productive worker is added the expense of frequent successions of illegitimate children to which the defective mother gives birth, one pictures a situation that cannot be described or understood except by those who have lived through it. Many a decent poor family has been wrecked or dragged below the poverty line by reason of such an experience.

The feebleminded mother, in addition to her mental impairment, is frequently physically impaired. Her mental condition often indicates profound bodily maladjustment and so she is not equal to the continuous physical strain which life involves for most of us.

A survey of the situation in Massachusetts calls for an extension of care on the part of the state for every feebleminded girl or woman capable of bearing children and who cannot be protected out in the community. Many girls and women who are defective mentally may safely stay in the community if under careful oversight. Many of us know of instances where this plan of family care is being safely followed.

It should be a uniform practice to separate defective mothers from their babies just as soon after birth as the attending physicians deem wise. We have too many feebleminded mothers in this state known to public and private charitable organizations who are responsible for the care and training of their children. The presence of the baby with the defective mother does not serve as a check to further illegitimate babies and does mean improper care for the baby. Such illegitimate babies born to defective mothers should become automatically wards of the state. I don't mean by this that the state should necessarily remove the baby from the mother's people, but it certainly should be able

to prevent the mother disposing of her baby at will. If intelligent people knew of the numbers of babies born to defective mothers, who are given away for adoption to people who know nothing about their history and background, this suggestion would receive a wider support.

The forces which tend to impair men and women and to make them degenerate are so numerous and so active that there can be no question of the desirability of laying a heavy hand on the tragic process of breeding children, frequently defective, by defective mothers.

FEEBLEMINDEDNESS AND PROBATION*

HERBERT C. PARSONS

Deputy Commissioner of Probation, Boston

SO naturally and spontaneously has probation developed in Massachusetts that its people, at least those not directly concerned with the correctional problems, are found to be almost unaware of its existence and quite unknowing of its extent, not to say of its intention. It is a fact, however, that probation has come into the major responsibility in our dealing through the courts with offenders against the law.

A definition of probation is not easy. Perhaps the best one is reached when we say that "probation is a process by which the courts, pending disposition of the case, or under suspension of sentence, place a person convicted of crime in the care of a probation officer, with a view to reformation." Too great emphasis cannot be put upon the final word "reformation." It is important in this discussion because we are confronted with the question whether persons who are mentally defective are properly included in the scope of its purpose.

The feebleminded person brought to the bar of justice presents one of the most difficult problems of the courts. As yet, no clear path is provided for his disposition. The courts have no power to commit him directly to a school for the feebleminded. He may be sent there only by resort to the probate court, under precisely the same law as applies to the insane. He may not be sent to the insane hospital and, if sent, would be most unwelcome there. He may be sent to a jail or prison and in fact is so sent, to such number that at least one fourth of the population of correctional institutions is made up of such as he. The prisons do not want him and have nothing to offer him. An easy disposition is to place him on probation and I regret to say that in numbers almost appalling probation is resorted to and is forced to assume a responsibility which it is not equipped to discharge and which is, indeed, distinctly foreign to its intent.

Over the gateway of probation through which the courts are sending a constantly increasing procession of offenders, there

*Read at the Conference on Feeblemindedness of the Massachusetts Society for Mental Hygiene, Ford Hall, Boston, December 14, 1916.

might well be placed the sign "No feebleminded wanted here." Beyond that gateway stand the probation officers, appointed by the courts, extending a helping hand to those whom the courts have considered capable of being helped by diligent kindness. Obviously, to commit to the care of probation officers those who at the outset are seen not to have capacity for response to the efforts made in their behalf is unjust both to the object of this intended favor and to the officers who undertake the work. It is a prime essential of the probation effort that there shall be a fitness for reformation and reconstruction in the person in whose behalf it is exercised. Its sole purpose is to bring persons who have come within the reach of the courts into a habit of obedience to law and such a readjustment as to secure, so far as is possible, their right conduct, not only during but beyond the period of supervision. We who are concerned in the right use of the probation service are growing insistent that it shall not be employed simply as a means of disposal of difficult cases. For example, the courts are being urged to find other disposition for a large proportion of the persons convicted of drunkenness, among whom there are many whose condition clearly forbids the hope that they can be helpfully dealt with by this process. It has not been infrequent for the courts to place on probation men in whose cases the brightest prospect is that they will take themselves promptly beyond the borders of the state. It takes no argument to show that these classes are improperly handled when they are assigned to officers who exist for the purpose of helping men and women to right conduct. If to their numbers are added, as is actually done, persons without mental accountability, the service becomes loaded with a burden which hampers the discharge of its really vital duties to the courts and to society. Probation is an instrument to be used with an appreciation of its fine social and individual possibilities and its edge should not be deliberately blunted by requiring its exercise upon unyielding material.

So much for the protection of the probation service in its actual responsibility. Let us consider the case of the person himself and how far probationary treatment has a possibility of benefit. Probation holds out no promise beyond the supervision necessary to bring about right conduct in more or less responsive persons. It is equipped none too well for the task of dealing with the normal minded. It is totally unequipped for the special dealing with, or treatment of, the subnormal. There is no need

to say that the person with subnormal mentality needs special treatment, a treatment largely custodial.

There is great attraction in the possibility of out-patient care of the feebleminded. Doctor Wallace, superintendent of the Wrentham State School, in his report* for the year 1914, outlined a system for the supervision by the state of mental defectives in their own homes. Recently Doctor Fernald† presented the possibilities of this extension in most attractive form. But it must be by organization quite distinct from the probation service of the courts for at least two reasons: first, that the probation service is amply occupied with its reformatory task; and, second, that it reaches only those cases which come by the avenue of the court, by no means including all those who require the supervision which the superintendents of our institutions advocate.

Injustice, however, would be done to the probation officers if they were put in the light of resisting any task put upon them by the courts. As the state is now organized, the misplacing of the feebleminded is unavoidable. The probation service must take and is disposed to take its share of a burden which rests unfairly and unjustifiably upon all branches of the correctional work. Ultimately there will be a determination in every doubtful case of the mental condition of the person whose disposition is the court's problem. Actually but one court in the state is today officially equipped with the means of determining the mental status of the offender. The Boston Municipal Court acquired this equipment under the cover of its probation officer but the legislature of this year has provided for its separation as a distinct service.‡ There is assurance that the Boston Juvenile Court is presently to have its mental clinic by the establishment of a fund through private subscription,§ as a memorial to the judge who made this court the model for the world. These courts, with their jurisdiction limited to but a section of the city of Boston, are no more than furnishing an example to the rest of the state. Until the day comes when every court is similarly equipped and when every person brought before it shall have the

*Wrentham State School. Eighth Annual Report, Boston, Wright & Potter, 1915, p. 14–15.

†What is Now Practicable in the Way of Probation, Education, Supervision and Segregation of the Feebleminded. Walter E. Fernald, M.D. To appear shortly in the *Journal of Education*.

‡Dr. V. V. Anderson, psychiatrist.

§The Judge Harvey H. Baker Fund.

benefit of mental examination to determine in what place and by what means he may best be helped, the existing agencies must need share the unscientific and irrational assignment to them of persons for whom they can do but a fraction of the good their cases demand.

Moreover, the discovery of mental defect in the offender may never fully determine that there is no hope of his restoration to a right social status. The degree of responsibility in the offender varies with every individual case. Hence, while mental defect is evident, it may not be the major feature in the case and such helping effort as the probation officer may give may, after all, be well expended and bring about precisely that correction which the service exists to accomplish.

At all events, as matters now stand, probation officers may readily be pledged to do their part in dealing with this doubtful element in our problem, and they are doing so. To an extent, the probation service may serve as an observation field—a trying-out ground—and this it is actually doing. The alternative of commitment to jail is infinitely worse from the standpoint of the person, and vastly more costly from the standpoint of the public. No rigid rule for a moment would be urged under existing circumstances for the probation officers to resist the assignment to them of doubtful or even of fairly well-determined cases of feeblemindedness.

Whatever service may be done by probation officers for the feebleminded must, however, be treated as a concession—a very gracious and a very humane concession to the present imperfect organization of the state. This instrumentality of upbuilding can only temporarily be regarded as the one for the care of any portion of the mentally disordered or the mentally defective. Its growth into a larger measure of usefulness depends upon a closer selection of the material committed to it. In its behalf there may be waived a strict requirement of fitness in its charges, but we must continue to insist that it is not the instrumentality for dealing with persons whose mental outfit is such as to make their presence in the community a hazard to the neighborhood and much less than an assured benefit to themselves.

SEGREGATION OF THE UNFIT IN REFORMATORIES*

GUY G. FERNALD, A.M., M.D.
Resident Physician, Massachusetts Reformatory, Concord

THE purposes of classifying the population of an institution, that of a prison for instance, may be regarded as proximate and ultimate. When the proximate purposes of classification are realized, the numbers and personnel of essential groups presenting significant characteristics are determined and when the ultimate purposes are realized the actual physical differentiation of certain groups may take place and the adaptation of suitable treatment and training may be most economically begun.

The actual physical segregation of all groups one from another is not necessary nor desirable; but that certain prisoners should not be associated with those who would be contaminated or retarded by such association is evident. At the Massachusetts Reformatory, where the population constitutes a fairly homogeneous group, the average age being twenty years and the average sociologic deviation very small, not even a preliminary survey was needed to reveal the existence of a class or group whose unrestricted association in the schoolroom and workshop or on the farm was a distinct retardation and detriment to both themselves and the other inmates. This group, the existence of which was easily recognized, has been found in our classification studies to be of an intrinsically weak or defective mentality. The group includes about 15 per cent of the Reformatory population and its members are popularly known as "defective delinquents" or "feebleminded." For our purpose the term "segregable" is more definitive, however, and is therefore used. It is clear that members of this class should not be imprisoned or trained in contact with those of ordinary mental capacity and unlimited responsibility. Their proper care calls for slow training in an environment adapted to their limited capacity and peculiar needs where they should be sheltered until their return to society can be effected under conditions assuring protection to the community.

The proximate purpose of the laboratory studies of inmates at the Massachusetts Reformatory is the demonstration of this

* Read at the Conference on Feeblemindedness of the Massachusetts Society for Mental Hygiene, Ford Hall, Boston, December 14, 1916.

group of unfit, mostly feebleminded, in size and personnel, so that it may be known who and what they are. The accompanying syllabus shows the result of our individual examinations and classification of 1,107 inmates in the last two years. Since the departure of the unfit from normality and their inability to compete in the community unaided is measured by a variety of mental departure as well as by degrees of mental efficiency, we have endeavored to show these differences in our diagnoses, a survey of which follows:

Cross-reference Syllabus of Psychopathic Diagnoses

Massachusetts Reformatory, Concord, 1914–1916

GRADES OF EFFICIENCY

Intramural descriptive designations		Adult	Subnormal	Segregable	Total	
Competent	Accidental offender	50	1			
	Responsible offender	347				398
Deviate	Recidivist		118	27	145	
	Psychopath		159	22	181	
	Epileptic		16	9	25	
	Congenital syphilitic		16	11	27	
	Sex pervert		6	10	16	
	Insane			10	10	404
Deficient	Moron		155	77	232	
	Imbecile			3	3	235
	Unclassified	52	17	1		70
	Total	449	488	170		1107
	Percentage Rate	40.6	44.1	15.3		
Included Above	Alcohol addict	152	239	56	447	
	Drug addict	9	13	4	26	

The attempt has been made to draw the line of demarcation between subnormal and segregable, to separate those capable of supporting themselves honestly and unaided from those unable to live honestly without surveillance.

Referring to our tabulation, it will be noted that neither the term "feebleminded" nor "defective delinquent" is exactly synonymous or co-extensive with "segregable." The purely feebleminded are the morons and imbeciles—very few of the latter in the Reformatory population. Many morons are tractable and the question of their segregation for training is not one

wholly of their deficiency; hence the segregable are designated. All the deviates are defective delinquents, but not all should be segregated. The word segregable has an administrative as well as a sociologic significance and distinguishes a Reformatory group of a certain limited degree of mental efficiency divided into several varieties of mental departure.

A few cogent facts that stand out clearly regarding this class of segregables in the Reformatory may be stated:

1. Members of this group are of demonstrably defective, deviate or alienate mentality and hence of limited responsibility (demiresponsible of Grassett), and as such should not be sentenced to serve with the fully responsible.

2. This group of defective and potential offenders has long existed in communities, courts and prisons but its existence and characteristics have been recognized only when numbers were assembled, as many have been, in the reformatories.

3. Members of this group present a variety of kinds and degrees of mental anomaly, disposition and character defect, as must be the case when the unity of normality is wanting; hence classification and individualization must be extended in treating this group beyond the limit of that required in the case of the fully responsible.

4. Existing institutions for the care of feebleminded are not adapted to receive defectives with vicious tendencies and training and the admission of the vicious element to association with the protected would result in harm to the latter; hence the logical custodians of the vicious defectives are the penal institutions.

5. Some form of special custodial care, in which the hospital features are prominent, providing for the absolute physical segregation and slow training to industrial usefulness and ultimate restoration to liberty, perhaps, is urgently needed for this group.

6. No provision for supplying the peculiar needs of this particular class exists in this state or in any other state, though Massachusetts has a law tacitly recognizing the existence of the defective delinquent, but carrying no adequate appropriation or plan. Commissions in several states are studying the problem and New York or Illinois will probably soon have something definite to offer. The New York City police department has just reopened its psychopathic laboratory for the diagnosis and classi-

fication of arrested offenders so that those of limited responsibility may be known before sentence.

7. Since there is no effective provision for this class of mental weaklings whom the probation officers cannot trust, the courts can do nothing else to protect the community and the defectives themselves than to send them to the reformatories.

Plans for the adequate care of those of segregation grade of mentality need not necessarily comtemplate an institution with new or separate administration, since absolute physical separation of inmates of inferior degrees of mental efficiency marks the essential point of divergence from the present system and, moreover, sufficiently emphasizes its principal defect. Furthermore, the segregation of the unfit would open the way for the stressing of the education of prisoners as the accepted means to the end of their reformation. Shall we not recognize the fact that the time is past when prisoners are simply occupied during sentence and shall we not proceed to take the next logical step in penalogy, *i. e.*, education during incarceration?

The juxtaposition of three trite sentences may serve to emphasize the importance of this point:

PRISONERS { unoccupied (as formerly) regress.
occupied (only) stagnate.
educated (as they may be) progress.

We have stated the ultimate purpose of classification to be the actual physical segregation of such classes as need that treatment. Not all the classes recognized as essential need segregation however. In the Reformatory to-day exist three grades or classes distinguished by differences of privilege and insignia, divided according to conduct. With the elimination of the 15 per cent of segregables, extension of classification among these three grades could proceed unhampered and the present differentiation, largely one on paper only, could become actual. If the physical constitution of the buildings at Concord permitted, an ordinarily well-equipped prisoner could be assigned on arrival to the second grade to be actually physically promoted or demoted, as his conduct should indicate, to the first grade with its added privileges and responsibilities, or to the third grade with its lesser comforts. And with promotion or demotion would come his transfer from one intramural community to another. Under these conditions a man disposed to seek self-culture and to achieve progress could measure his advancement and realize the rewards of well-doing as he can

not now do. So the segregation of the unfit is an imperative necessity and the augmented progress of the majority enabled thereby is a most important desideratum.

The value of the eugenic proposal that the feebleminded be prevented from propagation lies in its promise of ultimate relief from the "burden of feeblemindedness." The segregation of the unfit in reformatories under indefinite commitment, as are the insane, other feebleminded and epileptics, would enable the realization of the promise, so far as the most hopelessly unfit drifting in and out of the courts is concerned, since their segregation for training to self-support would prevent their propagation and eliminate one very perplexing factor in our sociologic and economic problem.

Finally, the indicated and adequate care of the members of this class of feebleminded prisoners with a vicious training and tendencies would not only greatly facilitate the solution of urgent penalogical problems, but would be a large contributing factor in the solution of the major sociologic problem, the conservation of mental hygiene in this generation and in those of the future.

SUMMARY

1. There is in most reformatories a small, fairly well-defined class of unfit inmates whose association on equal terms with the fully responsible is a detriment to both.

2. The unfit should be absolutely physically segregated in a specially constituted farm colony of which the hospital and laboratory features are prominent.

3. The larger group of fully responsible inmates should be actually physically divided into groups according to their conduct, provision being made for promotion and demotion from one intramural community to another.

ABSTRACTS

Survey of Mental Disorders in Nassau County, New York. July–October, 1916. A Report. By Aaron J. Rosanoff, M.D. N. Y.: National Committee for Mental Hygiene, 1917. Publication No. 9.

This is probably the most careful and thorough survey of mental abnormality in a district of considerable size that has yet been made. Nassau County has an area of 274 square miles and a population of 115,827. Every means short of a personal interview with each inhabitant was exhausted in the effort to make the survey complete; and in four small districts, in order to have data for comparison, every house was canvassed. The surveys of the British Royal Commission on the Care and Control of the Feebleminded covered sixteen widely separated districts in England, Scotland, Wales and Ireland with a total area of 6,688 square miles and a population of 3,913,806. The staff was relatively much smaller and consequently the work had to be somewhat less thorough.

The Nassau County survey was conducted under the auspices of the National Committee for Mental Hygiene. The Advisory Committee consisted of Dr. Charles B. Davenport, Prof. Stephen P. Duggan, Miss Elizabeth E. Farrell, Mr. Homer Folks, Dr. August Hoch, Dr. Aaron J. Rosanoff, Mrs. Charles C. Rumsey, and Dr. Thomas W. Salmon. The staff was made up of six physicians, of whom Dr. A. J. Rosanoff was Director, and fifteen field workers.

Nassau County was selected for a number of reasons, the chief of which was that it is a district probably as nearly representative of the population of New York state as can be found. It has many old families, and also a plentiful number of immigrants from many lands.

There are both rural and urban environments. Another reason was that the social agencies of the county are well organized and could be of great aid in numerous ways. Finally, the population is not too large to be covered in a limited time, and transportation facilities are excellent.

The director states that the problem the committee set out to solve is not the percentage of insane, feebleminded, or otherwise mentally defective persons, because it is now recognized that it is not possible absolutely to separate mental abnormality from normality, but "What instances of social maladjustment, sufficiently marked to have become the concern of public authorities, are, upon investigation, to be attributed mainly or in a large measure, to mental disorders?" Accordingly an effort was made to secure records of all cases of maladjustment brought to the attention of the authorities in the course of one year that might be due to mental trouble. Various local charitable and philanthropic agencies were consulted; the lists of the overseers of the poor, the dockets of the justices, and the records of the district attorney, of the Nassau County Association and of a number of New York state institutions were investigated; and all practicing physicians, neighborhood workers, truant officers, ministers, and old residents were interviewed. Furthermore, it was planned to visit the near relatives of persons found to be abnormal, with the expectation that certain cases not otherwise recorded would be thus discovered. It not infrequently happened that cases not disclosed by any of these means came to the notice of the field workers in the course of their daily visits.

It was felt, however, that even after all these sources of information had been exhausted some cases of abnormality would still be missed. In order to be able to estimate approximately the error due to these omitted cases, four districts, varying in population from 966 to 1,427, were subjected to intensive study, that is, to a house to house canvass. These districts were selected with a view to including all important elements of the population of the county.

Great care was taken to have the work of the field workers conform to one standard. It was a great advantage that all the workers were college graduates and that a number had had previous experience in this sort of work. In the beginning, printed instructions as to the manner of gathering information were given to the field workers, and later a simplification of the Binet system of intelligence tests was devised in order to give uniformity to the estimates of intelligence. Weekly conferences were held at which the chief problems encountered by the workers were discussed, and an attempt was made so to instruct them that their methods would be approximately uniform. When it was thought desirable, a full psychometric examination was given, and in all medical cases a consultation with one of the members of the medical staff was arranged. As a routine, the workers obtained information on the

following subjects: name, sex, age, marital condition, education, birthplace, race, how long in United States, residence, father's name and birthplace, mother's maiden name and birthplace, occupation and weekly earnings. In the abnormal cases information was also gathered concerning the family and personal history, development of psychosis, and the physical and mental status that is usually obtained in state hospitals.

Inasmuch as the primary interest was in those cases whose mental condition was such as to lead to maladjustment, two classifications were employed—a medical and a sociological one. These classifications are found in the tables which follow. It may be stated here, by way of explanation, that the medical heading "Disorders of uncertain nature or etiology" was formed to cover cases in which the data were incomplete and cases not fitting into the preceding groups (certain cases of inebriety, sex immorality, criminal tendency and dependency). Under the sociological classification "Medical cases" are instances of neuropathic conditions such as fainting spells, migraine, and "nervous prostration." Under "Other groups" are many conditions of which "incompetent housewife," "failure to support family," "sanitary menace," and "improper guardian" are descriptive terms used. In a hospital for the insane such diagnoses as "psychopathic personality," "constitutional inferiority" or "moral imbecility" would probably have been made.

As a result of the survey, 1,592 cases of mental abnormality and 583 cases of doubtful mental normality were discovered. The abnormal cases were distributed as follows in the medical classification.

Medical Classification of Abnormal Subjects

Medical classification	Intensive districts		In county at large		Total		
	No.	Per cent	No.	Per cent	No.	Per cent	Per 100,000 population
Constitutional disorders:							
Recoverable psychoses	3	1.8	48	3.3	51	3.2	44.0
Recurrent psychoses	3	1.8	45	3.1	48	3.0	41.4
Chronic psychoses without deterioration	9	5.3	41	2.8	50	3.1	43.2
Chronic psychoses with deterioration	9	5.3	129	9.0	138	8.7	119.1
Epilepsy	8	4.7	64	4.5	72	4.5	62.2
Arrests of development	72	42.3	561	39.4	633	39.8	546.5
Huntington's chorea			1	0.1	1	0.1	0.9
Disorders of exogenous origin:							
Traumatic psychoses	1	0.6	4	0.3	5	0.3	4.3
Alcoholic psychoses			34	2.4	34	2.1	29.4
Syphilitic psychoses			15	1.1	15	0.9	12.9
Other groups:							
Senile psychoses	8	4.7	25	1.8	33	2.1	28.5
Cerebral arteriosclerosis	3	1.8	15	1.1	18	1.1	15.5
Brain tumor			1	0.1	1	0.1	0.9
Cretinism and myxoedema	1	0.6			1	0.1	0.9
Disorders of uncertain nature or etiology	53	31.1	439	31.0	492	30.9	424.8
Total	170	100.0	1,422	100.0	1,592	100.0	1,374.5

The following table gives the result of the sociological classification.

Sociological Classification of Abnormal Subjects

Sociological classification	Intensive districts		In county at large		Total	
	No.	Per cent	No.	Per cent	No.	Per cent
Retardation in school	19	11.2	150	10.5	169	10.6
Truancy, unruliness, etc.	3	1.8	17	1.2	20	1.3
Sex immorality	23	13.5	93	6.5	116	7.3
Criminal tendency	6	3.5	73	5.1	79	5.0
Vagrancy			2	0.1	2	0.1
Dependency	31	18.2	249	17.5	280	17.6
Inebriety	35	20.6	285	20.1	320	20.1
Drug habits	1	0.6	3	0.2	4	0.3
Domestic maladjustment	3	1.8	11	0.8	14	0.9
Medical cases	9	5.3	48	3.4	57	3.6
Other groups	15	8.8	353	24.9	368	23.0
No maladjustment	25	14.7	138	9.7	163	10.2
Total	170	100.0	1,422	100.0	1,592	100.0

It is interesting to note that for about one fourth of these cases (chiefly the recoverable, recurrent, chronic, traumatic and alcoholic psychoses), good institutional provision is made by the state, while for the remaining three fourths, very little is provided. In the latter group some of the greatest menaces to the community are found and it is certainly to the interest of society that they should be confined in institutions.

It may here be stated that of the 492 cases falling in the group "Disorders of uncertain nature or etiology," 236 came under the sociological heading "Inebriety," 46 under "Dependency," 43 under "Sex immorality" and 58 under "Criminal tendency." Detailed histories of cases of inebriety, dependency, sex immorality, and criminal tendency are given in order to show how hard it is to classify definitely many cases of mental abnormality.

Of the 368 cases under "Other groups" of the sociological classification, 310 were in institutions and therefore not assigned a more definite place in the sociological classification. Some of the remaining 58 were described as "requiring constant care," "nuisance in community," "suicidal tendency," "sanitary menace," etc.

When arranged as to age, it was found that relatively few of the abnormal cases fell in the age period below five years. This is due to the difficulty in recognizing abnormality at that age. A relatively large number fall in the age periods above forty years, thus showing how the factors which give rise to mental abnormalities or serve to render them manifest, increase with advancing age.

Another table gives statistics concerning marital condition. It shows (1) the greater tendency of the abnormal group to remain single, and (2) the greater tendency of the same group to be divorced or separated. "It does not appear from these findings that there is ground for apprehension of any increase of mental disorders."

Four Groups of Subjects Compared as to Marital Condition

Sex	Ages	Group 1					Group 2					Group 3					Group 4				
		S.	M.	W.	D.	Sep.	S.	M.	W.	D.	Sep.	S.	M.	W.	D.	Sep.	S.	M.	W.	D.	Sep.
Male	11–20	284	4				255	4				93	3	1			162	2			
	21–40	178	473	3		2	103	162	1		2	28	38	1		1	137	80	1	1	15
	41–60	23	367	13	1	2	29	181	7	1	3	12	39	3		2	66	128	21	3	26
	Over 60	5	91	24	1	1	4	51	30		1	1	9	6			24	31	29		9
Female	11–20	334	18				227	12			1	70	7			1	139	6			3
	21–40	152	530	14	5	12	70	204	14	5	9	11	43	8		6	111	132	16		31
	41–60	28	298	47	1	8	21	161	45	1	10	5	42	11		2	31	101	40	1	17
	Over 60	8	55	65		3	6	33	42		2		5	7		1	11	15	41		3

Group 1—Normal persons with normal relatives.
Group 2—Normal persons with abnormal relatives.
Group 3—Doubtful cases.
Group 4—The abnormal cases.
Cases under 11 years of age or in which age or marital condition is unascertained have not been included in this table.
S = single; M = married; W = widowed; D = divorced; Sep = separated.

The table giving the average weekly earnings is interesting.

Earnings	Group 1	Group 2	Group 3	Group 4
	Per cent	Per cent	Per cent	Per cent
Under $7.00	0.8	2.7	10.4	33.0
7.00–10.00	9.3	14.9	29.2	32.8
11.00–20.00	57.9	66.4	52.9	28.9
21.00–50.00	30.0	14.7	6.6	5.0
Over 50.00	2.0	1.3	0.9	0.3

When the data as to education are classified, the influence of two factors, namely educational opportunity and educability, is shown in a rather striking way. "Thus, the foreign-born white in Group 1 make a poor educational showing obviously attributable in the main to lack of educational opportunity and not to low degree of educability, in view of the fact that their descendants, the 'native of foreign or mixed parentage,' are able, in the presence of good educational opportunity, to make a showing approaching that of the native of native parentage. Group 4, on the other hand, makes a uniformly poor educational showing in all its subdivisions, even that of the 'native of native parentage,' *i. e.*, in the presence of good educational opportunity; here, therefore, the poor showing is largely attributable to low degree of educability."

It is interesting to consider the treatment that has been provided for these abnormal individuals and the treatment it is judged they need.

History of sojourn in institutions	Intensive districts		In county at large		Total	
	No.	Per cent	No.	Per cent	No.	Per cent
Now or formerly in institutions	33	19.4	629	44.2	662	41.6
Never in an institution	127	74.7	747	52.6	874	54.9
Unascertained	10	5.9	46	3.2	56	3.5

Treatment required	Intensive districts		In county at large		Total	
	No.	Per cent	No.	Per cent	No.	Per cent
Institutional care	74	43.5	872	61.4	946	59.4
Other treatment	68	40.0	386	27.1	454	28.5
None	28	16.5	164	11.5	192	12.1

These two tables are also of interest.

Amount of Institutional Care Actually Available for Cases Judged to Require it

	Intensive districts	In county at large	Totals
Now in institutions	8	357	365
Have been in institutions, now at large	21	216	237
Past sojourn in institution unascertained, now at large	7	28	35
Have never been in an institution	38	271	309
Totals	74	872	946

Rough Classification of Cases Judged to Require Institutional Care and Not Receiving it

	Intensive districts	In county at large	Totals
Insane	10	98	108
Feebleminded	21	168	189
Epileptic	1	6	7
Other psychopathic groups	34	243	277
Totals	66	515	581

In the following table is given the sociological classification of the cases judged to require institutional care.

	Intensive districts		In county at large	
	Primary item	Secondary item	Primary item	Secondary item
Retardation in school	5	1	50	7
Truancy, unruliness, etc.		2	8	11
Sex immorality	18	22	63	72
Vagrancy			2	12
Criminal tendency	3	10	22	65
Dependency	4	13	69	119
Inebriety	33	9	207	30
Drug habits	1	5	2	1
Domestic maladjustment		12	5	93
Medical cases		1	3	3
Other groups	2		76	13
No maladjustment	1		7	
Totals	67	75	514	426

The following table also gives some very interesting data.

Kinds of Institutional Care Actually Available or Given in the Past to 662 Cases

	Intensive districts	In county at large
State hospitals for the insane	7	203
Private sanatoria	3	44
State hospitals for the criminal insane	1	6
Lock-ups or jails	17	123
Penitentiaries	3	20
State prisons	2	33
Reformatories	4	24
Training schools for delinquent children	3	36
State institutions for feebleminded or epileptic		42
Almshouses		62
Private institutions, at expense of the county	3	109
Totals	43	702

The work in the schools was done independently of the rest of the survey by a special detail of physicians from the United States Public Health Service under the direction of Surgeon Taliaferro Clark. A total of 2,500 pupils were examined and of these, 52 were classed as abnormal, 14 as probably feebleminded, and 116 as retarded. Comparing these results with those obtained in the survey made outside of the schools in the districts from which these pupils came, one fact is out-

standing, namely, that the majority of abnormal cases among children of school age are not to be found in the schools.

The last section of the report gives an evaluation of the findings and a discussion of their significance.

Comparing the main result of this survey (percentage of abnormality 1.72) with that of the British Commission (average percentage of abnormality 0.82), and carefully considering the methods employed in each survey, it seems clear that the contrast is due to the difference in methods. The British survey is evidently much less thorough.

The results in the four intensive districts indicate that some cases have been overlooked in the Nassau County survey. The question of the best method of making a survey—whether that employed in the intensive districts, or that in the county as a whole, or a combined method—must largely be determined by special objects in view and by local conditions.

"The survey has shown very clearly that for the bulk of cases presenting psychiatric problems, the benefit of psychiatric study, judgment, and treatment is not available." Of 946 cases judged to require institutional treatment, only 365 were really in institutions. The State of New York provides for 396.3 insane, epileptic and defective persons per 100,000, and according to the survey, 816.7 per 100,000 are in need of custody. Hence the capacity of the New York institutions could be doubled without any danger of having space unused. This would really be an economy for the people of the state, for in such institutions the annual cost is between $150 and $200 per capita, while under the present arrangement the maintenance of these cases at large and the losses arising from trials, theft, the spreading of venereal infection, and other antisocial actions undoubtedly greatly exceed these amounts.

The following types of institutions are needed: (1) schools and colonies for the feebleminded, (2) separate institutions for defective delinquents (3) industrial colonies for inebriates, vagrants, etc., and (4) provision for epileptics.

It is recommended that a system of registration of cases admitted to institutions, or coming to light in the courts or schools that may be due to mental abnormality, be instituted. It is also suggested that it would be well to try out in one state a model system of psychiatric treatment, which would be financed by bond issue and endowments from private sources, and which would serve as a working model for other states.

FORTIFYING THE CHILD AGAINST MENTAL DISEASE. By JESSIE TAFT. *American Education*, September 1917.

Miss Taft urges an extension of the activities of the school in the field of mental hygiene. She points out that it is now an accepted function of the school to look after the physical condition of the pupils and that

more and more efforts are being made to sort out subnormal children in order to afford them the training best suited to their capabilities. There has been little effort, however, to study with regard to their mental habits, peculiarities, and methods of adjustment to surroundings, those pupils who are normal in intelligence.

It is just as important to adjust instruction to meet the needs of the child in the sphere of will and emotion as it is in that of intelligence. If this is done not only will the normal child acquire habits that will contribute to his success and happiness all through life, but the child who is by heredity predisposed to mental disease may be able to avoid a mental breakdown. It is not a contraindication that in most instances it is impossible to separate out the latter group because the training that is valuable to the child normally constituted is exactly that needed by the child with bad heredity.

It is also possible by proper instruction to do something toward preventing those mental disturbances that are caused by syphilis, alcohol, and drugs.

The article is written by a well-informed layman for the lay reader, and will be found valuable by parents, teachers, and those interested in social service work.

DECLINE OF ALCOHOL AS A CAUSE OF INSANITY. By HORATIO M. POLLOCK. *Psychiatric Bulletin*, April 1917.

The author bases his conclusion that there has been a decline in alcohol as a cause of insanity on the results of a statistical study of the 58,011 patients admitted to New York state institutions between October, 1908, and July, 1916.

"The most striking fact shown by the table* is the gradual decrease in the percentage of cases of alcoholic insanity annually admitted from 1909 to 1915. In 1909, the percentage of alcoholic cases among all admissions was 10.1; in 1910, 9.8; in 1911, 9.7; in 1912, 9.4; in 1913, 9.0; in 1914, 7.0, and in 1915, 5.4. In 1916 there was a slight change in the trend and the percentage rose to 5.7. It will be noted that the annual decrease was slight down to 1913, but very marked during the two succeeding years. The percentage of alcoholic cases among re-admissions is constantly lower than among first admissions but the reduction during the period was very similar in the two groups.

"If the facts concerning the decrease in alcoholic insanity above set forth stood alone they might be interpreted as being due to changes in diagnosis rather than to changes in the use or influence of alcohol. Additional light is thrown on the matter by the record of the intemperate use of alcohol by first admissions during the eight-year period as shown by Table 2. It appears from this table that 11,301, or 24.8 per cent,

* Table 1.

of the 45,661 first admissions used alcohol to excess. Among the males the percentage was 36.8, and among the females, 11.2. Comparing the yearly percentages of excessive use, we note a general decline from 1909 to 1916, with the exception of 1910. In that year the term 'habit disorder' was used in tabulating instead of 'intemperate use' and moderate drinkers were included. The trend in the use of alcohol is clearly shown by the data for the other years. In 1909, the percentage reported as using alcohol to excess was 28.7; in 1911, 24.3; in 1912, 23.8; in 1913, 23.5; in 1914, 20.5; in 1915, 18.7; and in 1916, 18.5. Here again the decrease became more marked in 1914 and continued the succeeding year.

"The foregoing data give comparisons year by year between the alcoholic patients and the non-alcoholic. The rate of new cases with alcoholic psychoses per 100,000 of general population in 1909 was 6.3; in 1910, 6.4; in 1911, 6.4; in 1912, 6.0; in 1913, 6.0; in 1914, 4.8; in 1915, 3.6; and in 1916, 4.0. The reduction in rate was most marked in 1914. A further reduction occurred in 1915 but the downward trend ended here and a slight rise is observed in 1916."

THE NECESSITY FOR MEDICAL EXAMINATION OF PRISONERS AT THE TIME OF TRIAL. By PAUL E. BOWERS. *Journal of Sociologic Medicine*, June 1917.

The writer advocates the examination of prisoners before trial from the standpoint both of justice to the accused and of economy to the state. It is obviously wrong, he states, to bring to trial those who are not responsible because of mental defect or insanity. The proper places for these persons are special hospitals, and not jails from which they will be discharged as soon as their sentences have expired and regardless of whether they still are a menace to society. They present problems which are for the psychiatrist and not for the judge to solve.

Furthermore, the saving to the state in the avoidance of useless trials would be considerable. The writer refers to an investigation of his own made on one hundred recidivists, all of whom had been convicted four or more times. He found that twelve of these were insane, twenty-three feebleminded, and ten epileptic. Altogether 180 trials had been held for these abnormal persons at an estimated cost of $180,000. He makes the statement that 75 per cent of the men who appear before the disciplinary officer of the Indiana State Prison are mentally defective.

He advocates such a revision of the laws as would make it possible for the court to have in its personnel a competent psychiatrist whose duty it should be to examine each prisoner at the time of his arrest and trial.

THE PSYCHOPATHIC EMPLOYEE; A PROBLEM OF INDUSTRY. By MARY C. JARRETT. *Medicine and Surgery*, September 1917.

After comments upon the lack of recognition, on the part of most employers, of psychopathic conditions among employees, and upon their ignorance of the important effects of such conditions upon industrial efficiency, Miss Jarrett outlines the work carried on for two years by the Social Service Department of the Boston Psychopathic Hospital to investigate the industrial difficulties of some of its patients. This work was in two parts—intensive social care of a few cases, and investigation of the industrial histories of many. Miss Jarrett says: "The group chosen for study was men between the ages of twenty-five and fifty-five, who had not been industrially disabled up to the time of the illness that brought them to the hospital. The industrial history has been obtained from both patient and employers. A tentative report of the first one hundred cases studied was written by Dr. Adler and published in the first number of *Mental Hygiene*, January, 1917. . . . The other section of the work, confined to a small group of patients, has been an effort to adjust the patient to his occupation." After giving a few statistical summaries of interesting data brought out in the study of these patients, Miss Jarrett cites some of the cases themselves. The article is followed by a series of charts prepared to give a quick view of results of social work in psychopathic cases of this kind.

ORGANIZATION OF PSYCHOPATHIC WORK IN THE CRIMINAL COURTS. By HERMAN M. ADLER. *Journal of Criminal Law and Criminology*, September 1917.

There seems to be an increasing tendency on the part of courts to concentrate attention on the criminal rather than on the crime. In pronouncing sentence the judge is now apt to consider not how best to punish the accused for his crime, but what course of procedure is most likely to make of him a permanently law-abiding citizen. The writer points out the value of a psychiatrist's working in connection with the court as follows:

"Psychopathic work in connection with the criminal courts accomplishes two purposes. In the first place, it classifies the individual delinquent or criminal not according to the type of his act nor according to the amount of damage done, but according to the elements of his personality. In other words, it attempts to disclose the underlying causes of the particular act which brought the delinquent into court. In the second place, on a basis of such facts as this examination discloses, a plan of treatment may be devised to suit the needs of this particular individual rather than the general requirements of his type.

"One of the reasons why psychopathic laboratories in connection with criminal courts are still open to objection by a large proportion of the

legal profession, is probably because up to the present the emphasis has been laid almost entirely upon the classification of criminals. Such classification, while of scientific value, is after all largely academic, unless it is made the basis of treatment.

"In medicine the diagnosis is apparently over-emphasized at times, at least in the eyes of the layman, merely because if once a correct diagnosis has been established the proper treatment is a comparatively obvious matter.

"It is toward this latter side of the work that the energies of the community must be bent so that the scientific classification of criminals by scientists may be made of practical use to the courts."

A psychopathic clinic in connection with the courts will yield results in direct ratio to the amount of money expended. It should be sufficiently equipped with personnel to be able to cover every case brought before the court. There should be psychiatrists for mental examinations and psychologists for mental testing. There should be a sufficiently large social service staff to gather information concerning the surroundings from which the prisoner comes, to take care of the follow-up work, etc. In charge of the clinic should be a trained psychiatrist not only with executive ability but with a mind capable of appreciating and working out new problems as they arise. A special building in which baffling cases could be detained until they had been properly studied would be necessary. One such institution could be made to serve a number of courts.

The preliminary outlay and the running expenses for such plan would be large; but the results would be commensurate both from a moral and from a financial standpoint. It would be possible to give to the judge, at the time of trial, information as to the prisoner's mental condition and advice as to the proper disposition if the prisoner happens to be abnormal. Those sent to institutions could be kept under observation and those discharged on parole or on probation could be helped in readjusting themselves.

Unfortunately it has not yet been possible to arouse public interest sufficiently to assure adequate support from the city or state for this program. The clinics now in existence are largely supported by private contributions.

FIFTH ANNUAL REPORT OF THE BOSTON PSYCHOPATHIC HOSPITAL. Reprinted from the Eighth Annual Report of the Boston State Hospital for the Year Ending November 30, 1916. Report of Director. Pp. 36–37; 46–47.

"One of the most important reasons for establishing the Psychopathic Hospital in its place in the Longwood group of medical institutions was the effect which its material and ideals would have upon the future

practitioner, namely, upon the medical student. There can be no question that the students of the local medical schools are now getting an insight into mental disease such as their predecessors in mental training have often failed to get until they were many years out in practice. It will be recalled that no physician is allowed to make a certificate of insanity (by the provisions of section 32 of chapter 504 of the Acts of 1909) unless he has been in the actual practice of medicine for three years after graduation. This doubtless wise provision of the law, embodied as it is in the law of numerous other states, seems to prove that the public would have no confidence in such a certificate unless a man had become somewhat matured in his attitude to the public, social and medical problems of insanity. It is a curious thing that the medical graduate of the present time in Boston, in Ann Arbor and in Baltimore is probably far better able to make a certificate in insanity upon graduation than any of the graduates in medicine of much greater age and more mature experience. The mental cases are taken by the student no longer as *curiosa*, but as medical problems. There can be no doubt that observations of the medical men made thus early in their medical training upon public and social problems will give physicians of the future in our community a much superior and more effective grasp of public and social problems, will make them public-spirited, and will tend, as the phrase is, to socialize them; but more important still, these practitioners will be able early to cope with the problems of feeblemindedness at an early age in their patients, with the problems of alcoholism and delirium tremens as seen in general practice, and with the highly important matter of early treatment of syphilis of the nervous system. What effect this may have on the future intake of the insane into our district hospitals is a matter for conjecture only. It may be that our district hospitals will never diminish the number of patients taken in, and they may even increase the number, but it is possible that the quality of the cases admitted will gradually alter in such wise that milder and milder and more and more incipient cases will be referred to state hospitals by physicians having confidence that the highest grade of psychopathic hospital service is available for cases demanding it, and that the highest grade of receiving ward service will be immediately available for cases requiring direct commitment to the district hospitals.

"One effect of our recent work has been to widen the scope of the Psychopathic Hospital activities thus: whereas there were in 1915, 514 regular court commitments to the Boston State Hospital out of 721 regular commitments in all, during the present year, 1916, there have been 399 commitments to the Boston State Hospital out of the larger total number, 831, of regular court commitments. The number of temporary-care cases has increased at this time from 1,083 to 1,213, but this increase has been largely from non-metropolitan districts. The

argument is plain that the extension of the psychopathic hospital grade of service is gathering force. . . .

"The social service department is integrally connected with the wards as well as with the out-patient department, but on account of the extramural work of the social service, the administrative and external connections of the social service are more intimate with the out-patient department than with the wards. The out-patient department of the Psychopathic Hospital is now a permanent and established feature of an organization so systematized that we can somewhat closely estimate in advance the work done. There were 1,485 new cases in the out-patient department, an advance upon the figures of last year (1,426). It is remarkable that although no concerted effort toward publicity of this department among the laity has been made, 167 people resorted to the out-patient department on their own initiative; 40 others were sent to the hospital at the suggestion of laymen not connected with public or private agencies; 104 patients were referred by physicians; 364 by public organizations devoted to charity; 193 by hospitals (either by physicians or social service departments); 97 from courts and 69 from schools.

"Of after-care cases there were 220 from the Psychopathic Hospital itself and 30 from other State hospitals. Quite the most considerable problem in the out-patient department is the question of mental defect, for which no less than 474 cases were referred. This feature of the out-patient department indicates what value the community attaches to our psychological examination, executed, we believe, upon a more systematic basis than elsewhere, except at the Waverley School for the Feebleminded, itself. Another rather extraordinary feature was that 209 cases were referred to the out-patient department on account of a question whether syphilis of the nervous system was present, and if syphilis was present whether treatment for the patient or the family could be instituted. There were 152 cases referred or resorting for psychoneuroses, and 66 cases for speech defect. There were 88 cases of delinquency, 41 of which were sexual.

"If we attempt to analyze the out-patient cases from the standpoint of the social problems presented, we find that a question of medical diagnosis with a view to the rendering of a social decision leads with a list of 464 cases. Four hundred and thirty-five cases brought up the question of institutional care. Other social problems, such as juvenile delinquency, illegitimacy, sex delinquency, bad home conditions and unemployment, are represented in our groups. For those who feel that social problems are of infinite dimensions, and that perhaps no case is without its problem, socially speaking, it is remarkable to note that no less than 361 of the 1,485 new cases in the out-patient department presented no social problem worth public consideration.

"The picture of the out-patient activities is not complete without analysis of the new patients. The resort of new patients (1,485 in all)

ranges in months from 93 to 160, but there were in all 9,261 visits by patients during the year, the monthly rate varying from 678 to 938. Accordingly, on each out-patient day there are on an average 32 visits by patients. Those who are familiar with the operation of out-patient departments in general must remember that 32 mental patients in an afternoon, whether their problems are new or old, form a considerable mass of difficult public, social, individual and medical problems for any staff to handle. These cases cannot be dismissed with placebo or fragmentary advice. The standard has been maintained of mental tests where required, of Wassermann examinations of the blood where required, of elaborate history-taking and of systematic recording. Meantime the individuality of the patient must not be forgotten."

THE FEEBLEMINDED. By WALTER E. FERNALD. *Educational Review*, September 1917.

". . . In some respects, our present plans of dealing with feeblemindedness recall Charles Lamb's story of the oriental method of purveying roast pig. Surely, it is no longer necessary to burn down the house every time we wish to put roast pig on the menu. This conference is really a checking-up of our knowledge and a mobilization of our resources, preliminary to a concerted and correlated drive upon feeblemindedness all along the line. All of the people who come in contact with the feebleminded feel the need of some organization, perhaps some governmental authority, for the supervision, protection, education, assistance and control of all the feebleminded persons in the state who are not properly cared for by their friends. This proposal is not so radical as it seems, for a large proportion of feebleminded persons at some time in their lives now come under the jurisdiction of public authorities or private societies as dependents or as irresponsible law-breakers. Many feebleminded persons eventually become permanent public charges. Many run the gauntlet of the police, the courts, the penal institutions, the almshouses, the tramp shelters, the lying-in hospitals, and often many private societies and agencies, perhaps eventually to turn up in the institutions for the feebleminded. At any given time, it is a matter of chance as to what state or local or private organization or institution is being perplexed with the problems they present. They are shifted from one organization or institution to another as soon as possible.

"At present, there is no bureau or officer with the knowledge and the authority to advise and compel proper care and protection for this numerous and dangerous class. This class of the feebleminded might be supervised by some existing organization like our Commission on Mental Diseases, or perhaps a State Board of Health, or by a special board or official; but the responsible officer should be a physician trained

in psychiatry, with special knowledge of all phases of mental deficiency, and its many social expressions. The local administration of this plan could be carried out by the use of existing local health boards, or other specially qualified local officials; or, perhaps better, by the utilization of properly qualified volunteer social workers, or existing local private organizations, already dealing with social problems. This systematic supervision and control could easily be made to cover the entire state, and would obviate the present needless, costly and futile reduplication of effort. The first duty of the new officer or bureau would be to state the problem fully by beginning a complete and continuing census of the feebleminded of the entire state. The recent surveys made in several cities and states, notably in Chicago, New York, Pennsylvania, Michigan and New Hampshire, show the feasibility of such a census. The assembling of existing data and records of physicians, mental clinics, court and prison officials, social workers, private societies, town officials, overseers of the poor, and special class teachers, would make an impressive beginning of the census. In Boston, the League for Preventive Work, representing sixteen private societies dealing with social problems, has begun such census and in a little over a year's work, has assembled data concerning over 1,600 feebleminded persons met with in their work during this period.

"Our compulsory school laws now bring every child to official notice. The school census alone, including as it does every child in the community, whether he goes to school or not, would in a very few years reveal and record the existence of nearly every feebleminded person. Such registration would be merely analogous to the required notification and record of cases of infectious and contagious disease. This co-ordination of existing records would be available for social workers, school authorities and other agencies, and would be of enormous service in the solution of the individual problems which the feebleminded constantly present. This, alone, would mean a great saving in time, effort and money. Once a person was adjudged feebleminded, a permanent accessible record would be made. This continuing census and registration of the feebleminded would make possible regular visitation of each defective who needs oversight by the trained social worker or by the local representative of the central bureau or board. The reports of these visitors, covering the life histories and family histories of many cases, would soon constitute an invaluable treasury of information as a basis for scientific research and study in the search for practical methods of prevention. The registration of every feebleminded person, and the regular visitation, especially of children of school age, would make it possible to inform the parents of the condition of the child, of the necessity of life-long supervision, and of the possible need of future segregation. The official visitor would advise the parents as to the care and management of the defective, and would have opportunity to inform

the family, the local officials, and the community generally as to the hereditary nature and the peculiar dangers of feeblemindedness. Suitable, tactful literature could be prepared, which could be gradually presented to the parents in a way that would have great educational value. If necessary, sooner or later, the parents will probably be willing to allow their child to be trained and cared for in an institution. In suitable cases parents who are not willing may be allowed to have the custody of their child, with the understanding that he shall be cared for properly and protected during his life, that he must not be allowed to become immoral or criminal, and that he shall be prevented from parenthood. Whenever the parents or friends are unwilling or incapable of performing these duties, the law should provide that he shall be forcibly placed in an institution or otherwise safeguarded. The local representatives of this central bureau would officially serve as advisors and sponsors for pupils graduated from the special public school classes for defectives, for court cases under probation and observation, and for institution inmates at home on visit or on trial. Under this plan, there would be a person in every locality familiar with the opportunities for mental examination and methods of permanent commitment. The extra-institutional supervision and observation of cases in their homes would do away with the necessity of institution care of many persons who would otherwise have to go to the institution, thus reducing the expense of institution buildings and maintenance of the institution. The expense of this plan of centralized supervision and control of the feebleminded may seem to be an objection, but it is not a valid one, for states like Massachusetts, New York, or Ohio, for instance, are now really wasting vast sums of money annually in haphazard methods of temporizing with the social consequences of mental defect, instead of dealing with the feeblemindedness itself. We are now pouring water on the smoke instead of on the fire. The central bureau would co-ordinate and utilize all the disconnected agencies which now deal with the feebleminded—the special public school classes, the child-helping societies, the mental clinics, the laboratories for social and eugenic research, the court and probation officers, and all the institutions for the feebleminded. The remote mountain village would be as well served as the large cities. The problem of rural feeblemindedness in this state has received very little attention."

NOTES AND COMMENTS

Legislation

California

The 1917 legislature passed an asexualization act amending one enacted in 1913 which repealed the 1909 law. As it now stands, the act provides for the asexualization of inmates of state hospitals for the insane and of the Sonoma State Home before they may be discharged. Provision is also made for the asexualization of any inmate of a state prison under certain conditions, when it would seem to be of benefit to him, in case he is a moral or sexual degenerate or pervert. This act does not apply to voluntary patients in any hospital. By the terms of this act any idiot may be asexualized with the written consent of parent or guardian.

Connecticut

The Commission appointed under a law passed in 1913 to investigate the matter of establishing a reformatory for women reported in favor of it in the assembly of 1915. However, no provision was made for the institution by that body.

The 1917 legislature has passed a law establishing this institution to be known as the Connecticut State Farm for Women. Women over sixteen years of age may be committed to it for any of the following reasons:

1. Convicted of, or pleading guilty to, the commission of felonies.
2. Convicted of, or pleading guilty to, the commission of misdemeanors, including prostitution, intoxication, drug-using or disorderly conduct.
3. Unmarried girls between the ages of sixteen and twenty-one years who are in danger of falling into habits of vice or who are leading vicious lives.

Only such may be committed as are likely to be benefited physically, mentally or morally by such commitment.

A law passed in Connecticut in 1915 (Chapter 294) is worthy of mention. It requires the proper town and city authorities in charge of the poor to have all the inmates of almshouses examined by a physician at least once in six months. In case any insane or feebleminded are found there, proceedings must be initiated for their commitment to the proper institution.

Florida

Acts 7283–7288 passed by the 1917 legislature place greater restrictions on the manufacture, traffic in, possession of, receipt of, transporta-

tion of, advertisement of and sale of alcoholic liquors. Another act provides that an application for a permit to sell liquors must be signed by a majority of the white registered voters, and a majority of the colored registered voters residing in the election district wherein the permit is sought.

By the provisions of House Concurrent Resolution 23 (1917), the commission which was appointed, under legislative enactment in 1915, to investigate the need of a state institution for the care of epileptics and the feebleminded is authorized to continue this investigation and to make a complete report at the 1919 session.

House Concurrent Resolution 26 directs the governor to appoint a committee of three citizens to investigate in regard to the location and erection of a new modern hospital for the insane. This committee is authorized to visit and inspect any sites offered as a location and to incorporate in its report all offers of land or money made by any community and to have plans and specifications prepared together with estimates of the cost of construction. They are to report at the next session of the legislature.

Massachusetts

Chapter 275 (1917) restricts the possession, sale, dispensing and administering of drugs.

The Wrentham State School has received an appropriation of $2,000 for the purchase of additional land, and the Gardner State Colony $3,500 for the same purpose.

The Commission on Mental Diseases has received an appropriation of $5,000 for an investigation as to the nature, causes, results and treatment of mental diseases and defects, and the publication of a report thereon.

Michigan

The Michigan Farm Colony for Epileptics has received two appropriations of $69,420 each for the construction and equipment of two cottages to accommodate 100 patients each—one cottage for the year 1918 and one for 1919. An appropriation of $35,000 has been made for a storehouse, bakery and meat market with $7,000 for their equipment.

The following appropriations for the state hospitals are worthy of mention:

Ionia State Hospital, $2,725.73 for purchase of additional land.

Kalamazoo State Hospital, $15,000 for a new laundry building and $26,654 for its equipment.

Newberry State Hospital, $35,000 for a new cottage.

Pontiac State Hospital, $74,000 for a new cottage.
Traverse City State Hospital, $14,461.50 for farm land.

Act 259 (1917) provides for the establishment and maintenance of the Michigan State Training School for Women to which women over sixteen years of age convicted of violating any penal statute of Michigan may be committed. The bill carries an appropriation of $100,000.

Minnesota

By the terms of a law passed in 1917, if a child who has been adopted develops, within five years after adoption, feeblemindedness, epilepsy, insanity or venereal infection as a result of conditions existing prior to his adoption, of which the adopting parents had no knowledge or notice, the adoption may be annulled and the child committed to the guardianship of the Board of Control.

Compulsory commitment of the feebleminded is provided for by Chapter 344 of the Laws of 1917. The provision for voluntary admission, obtaining previously, is retained, and the superintendent is given the power to detain any person admitted upon his own application as though he were committed.

New York

A bill which was enacted in the last session of the legislature makes it a misdemeanor for any one, except boards of health, licensed hospitals and dispensaries, to advertise in any way concerning venereal diseases.

Dr. Chester Carlisle, Senior Assistant Physician of Kings Park State Hospital, has been appointed Superintendent of the Division of Mental Defectives and Delinquents of the New York State Board of Charities. This division was created by legislative enactment in 1917.

Ohio

The state hospitals for mental diseases at Athens, Dayton and Massillon have received an appropriation of $10,000 each for a cottage for tuberculous patients.

A building for industrial betterment at the Columbus State Hospital has been provided for by an appropriation of $15,000 made by the 1917 legislature.

Pennsylvania

Act 59 (1917) permits the certificate of a physician as to the insanity of a patient to be sworn to before a judge or magistrate of any county, instead of limiting it to a judge of the commonwealth as formerly.

Act 259 (1917) amending one passed in 1913 to establish a state village for feebleminded women, removes the age restrictions, formerly between sixteen and forty-five years, and also provides that the mainte-

nance expenses, in the case of an indigent feebleminded woman, must be borne by the county, and not the commonwealth as formerly.

By the terms of Act 131 (1917) an indigent patient discharged from a state hospital for the insane receives from the hospital the amount of the travelling expenses to his home.

Act 399, which establishes nine county industrial farms, workhouses and reformatories, provides a separate apartment in each for inebriates.

By the terms of Act 274 (1917) the Western State Hospital for the Insane, established by legislative enactment in 1915, is authorized to receive as patients only those transferred from other hospitals for the insane.

The expenses incident to the commitment, removal and maintenance of the criminal insane will hereafter be a charge upon the county in which the crime was committed. The county, however, may recover these expenses from the estate of the patient, or from relatives liable for his support; but no such recovery may be had from the poor district in which the person had legal settlement.

In 1913 an act was passed to provide for the selection of a site and the erection of a state institution for inebriates. The 1917 legislature has appropriated $25,000 for this institution as follows: $100,000 for the purchase of land, improvement, water-mains, sewers and drainage pipes; $150,000 for the construction of buildings of which amount the governor approved $100,000.

South Carolina

Legislation enacted in 1917 aims to suppress intemperance and to prohibit the manufacture, sale and use of alcoholic beverages. One law makes it illegal to advertise them on street cars, railroads or vehicles, at public resorts, on billboards or circulars, and in newspapers and periodicals; and another regulates their transportation, storage and possession.

Act 121 (1917) provides for a board of regents for institutions for the insane. This board is to consist of five members appointed by the governor with the advice and consent of the senate.

Tennessee

Chapter 2 (1917) prohibits the receiving of orders for the purchase of alcoholic liquors, whether the liquors are in Tennessee or in some other state. This act became effective July 1, 1917.

Chapter 3 makes it unlawful for any person, firm or corporation to have intoxicating liquors intended for sale, after July 1, 1917.

Chapter 4 restricts the use of liquors for clubs, lodges and associations to one half of one per cent of alcohol.

Chapter 5 provides for imprisonment in the state penitentiary for from one to two years for persistent violators of the law against selling

intoxicating liquors as a beverage within four miles of a schoolhouse where a school is kept in the state.

Chapter 12 prohibits the receipt of intoxicating liquors from a common or other carrier, the possession after received and the shipment into the state or between different points within the state.

Chapter 115 provides for the extradition of persons of unsound mind.

The general appropriation bill provides $20,000 for two years to be expended in enforcing the prohibition laws. This sum may be used, with the governor's approval, for engaging special employes for this purpose.

Wisconsin

Chapter 235 (1917) requires physicians to report cases of venereal disease to the state board of health and to inform patients having these diseases of the danger of infecting others. The state board of health is authorized to commit infected persons refusing treatment to a suitable institution. Counties must care for indigent patients. Diagnostic work is to be free of charge.

Chapter 483 provides that no person having been afflicted with venereal disease shall be granted a marriage license, unless he can produce a certificate issued by an approved laboratory that he is not in an infective stage of the disease.

The Manitoba government will establish shortly a home for the feebleminded at Selkirk.

A movement is gaining momentum in Norfolk, Virginia, to give special instruction to mentally defective children in the public schools.

The board to locate the new Northwest Texas Insane Asylum, consisting of the governor, lieutenant governor, and the attorney general, are receiving applications from different cities. The board states that accessibility, convenience for the greatest number of inhabitants, water supply, building material, fuel supply, fertility of soil and healthfulness of location must be considered. Sites must contain at least 500 acres and be in the northwestern part of the state as defined by the law creating this institution.

Additional special classes for feebleminded are to be established in Cleveland, Ohio. All children suspected of being feebleminded are to be examined. There are at present about 600 defectives in 30 special classes in the city.

Two wards have been set aside at the Cook County Psychopathic Hospital, Illinois, for the care and treatment of mentally affected children. Nurses will be supplied from state and county service, and

occupational work will be provided. This is regarded as an emergency measure, and the state will be asked at the next session of the legislature to provide more adequate facilities.

Of 2,500 cases recently investigated at the psychiatric clinic of the Toronto General Hospital, 1,842 proved to be mental defectives, 51 per cent of whom were immigrants.

A movement has recently been started in Halifax, Nova Scotia, to establish additional special classes for mentally defective children. At present classes have been provided for about one fourth of the mentally defective children in the city.

The department of health of New York City has arranged to treat all patients suffering from drug addiction who apply at one of the city institutions. Co-operation is assured from the department of charities, Bellevue and Allied Hospitals, the board of inebriety and other city departments. The department of health will examine and prescribe or dispense drugs to addicts appealing to it, if such prescriptions are necessary, pending their admission to an institution or their treatment by a physician.

The new Iowa state hospital for epileptics has been completed and was opened on September 3. This institution comprises a group of one and two-story cottages, erected at a cost of over $500,000, with a site of 1,000 acres. It is located at Woodward about 25 miles from Des Moines.

The superintendent of schools of Berkeley, California, is making a survey of the schools to determine the number of children needing special training. Although only a preliminary investigation has been made, the conclusion has been reached that the number of mentally deficient children warrants the establishment of a clinic.

County supervisors in California have been urged by the state health department to provide in their annual budgets for hospital facilities for the care and isolation of patients suffering from venereal diseases. It is noteworthy that the governor has appropriated $60,000 from the state war emergency fund toward the control of these diseases.

On September 24 the cornerstone was laid for the first of eleven new buildings which are under construction at Randall's Island, for the New York City institution for the feebleminded. Some of the buildings which these new ones are replacing were erected fifty years ago.

Six large tracts of land—almost 150 acres in all—adjoining Byberry Farms have been purchased by the city of Philadelphia as sites for additions to the home for the indigent and hospital for the insane.

Many of the larger cities in Pennsylvania are taking steps toward the establishment of free mental clinics.

The building for male patients at the Wyoming State Hospital was destroyed by fire on September 14. A temporary building is being erected while awaiting plans for a new $150,000 structure.

The Wisconsin State Medical Society, in session in Milwaukee early in October, passed a resolution indorsing the plan to establish a state society for mental hygiene affiliated with The National Committee for Mental Hygiene.

The department of nursing and health at Teachers College, New York, has organized classes for the instruction of teachers, nurses, and social workers to meet the demand for teachers for the re-education of returned invalided soldiers and sailors.

As a result of examinations made voluntarily by Dr. Clinton McCord, a bill to establish a psychopathic clinic for the Albany County Court is being fostered by Judge Addington and will be presented at the next session of the legislature.

Additional Ungraded Classes for New York City

The board of education of New York City has requested from the board of estimate and apportionment an appropriation to provide for thirty-six additional ungraded classes for defectives. More than 1,300 children are reported as ready for these classes and it would require 89 classes to take care of them; but as there are only 36 rooms available the request is for that number of classes only.

The first special class was established in 1900 in one of the public schools in Manhattan for pupils unable to do regular grade work. At first this class included mental defectives and others; but later the others were removed until finally only children who were subnormal mentally were included. Additional ungraded classes were organized each year, and in 1906 a department of ungraded classes was created in the board of education. There are at present 224 such classes, with 4,107 pupils.

Clinics for venereal diseases have been established by the New York City department of health in each borough of the city. These clinics at the present time are for diagnosis and advice only. It is hoped that treatment may be instituted later. Under the supervision of the department of health, a hospital is being built in which will be segregated patients suffering from venereal diseases who refuse to co-operate in treatment. In order to have further control over the venereal disease problem in the city, the department has ruled that no treatment or diagnostic clinic for communicable diseases may be opened in the city without the consent of the department. Laboratories for diagnostic purposes cannot be opened unless the personnel and equipment is satisfactory to the department.

A psychiatric clinic is to be established on Staten Island with a resident psychiatrist in charge. This clinic will serve the department of education, the children's court and the department of charities, as well as the purposes of a general psychiatric clinic for the diagnosis and treatment of mental and nervous disorders and mental defect.

The Children's Bureau of the United States Department of Labor has recently published a report based on a study of mental defectives in Newcastle County, Delaware. This report reveals a close connection between poverty and mental defect, emphasizes the need of special training and permanent provision for institutional care and special protection for this class. Of the 212 cases of mental defect studied, only four or five were in well-to-do families; 62 per cent were at large in the community and only 5.7 per cent were in an institution for the feeble-minded. The majority of these cases were found in an environment making normal standards of living impossible.

An ordinance passed in June by the City Council of Chicago, requires that physicians must report all cases of venereal diseases to the department of health; that the physician, under penalty of a fine of $200, must give to each patient suffering from venereal disease, a booklet prepared by the department which deals with the subject; that each physician must keep in touch with his patients, and that if a patient absents himself from treatment for ten days, the department of health must be notified, the name and address of the patient being given.

Uniform Statistics

The Committee on Statistics of the American Medico-Psychological Association, which was appointed at the meeting of the association at Niagara Falls in 1913 to draw up a plan for uniform statistics in regard to mental diseases, agreed upon a classification and a set of standard statistical forms to be used in reporting data. The report of the committee was submitted to the association at its New York meeting in May, 1917, and unanimously adopted. The New York State Hospital Commission and the Massachusetts Commission on Mental Diseases have already adopted the classification of mental diseases worked out by the committee, and it is hoped that the other states will fall in line soon, that scientific studies may be made supported by reliable data.

The lack of uniformity in the statistical tables in the annual reports of the various institutions in this country do not permit deductions of a cumulative or comparative nature between the institutions in the several states. Through a uniform method of statistical study it will be possible to secure from the great wealth of material available in our hospitals, information which will aid very greatly in advancing our knowledge of psychiatry and serve as a basis for constructive work in

raising the standard of the care of the insane and in the work of prevention and reform.

Out-Patient Departments, Massachusetts State Hospitals

During the months of July, August and September, over 1,100 patients visited the mental clinics maintained by the Massachusetts State Hospitals. Of this number, about 550 came for their first visit. It is interesting to know that about 60 came on their own initiative. Over 50 were referred to the clinics by physicians; over 100, by charitable and other organizations; 20, by the schools; and 15, by the courts. About 40 came from other hospitals, and over 150 were patients discharged from the state hospital and reporting to the clinic for the first time. Over 2,000 visits were made to these clinics during these months.

For this same period, over 800 patients were discharged to after-care from the Massachusetts State Hospitals, and social service workers made over 1,500 visits to discharged patients. In this period over 30 were placed in families and over 50 returned from family care to the hospitals. Over 300 who had previously been boarded out were visited during these three months.

Military Neuro-Psychiatry

In June, 1917, there were in England from 160,000 to 170,000 pensioners. Colonel Sir John Collie, President of the Special Medical Board for Neurasthenia and Allied Nervous Disorders, and Director of Institutions for Neurasthenia under the Ministry of Pensions, estimates that roughly 20 per cent of these pensioners are suffering from functional nervous diseases.

Major Pearce Bailey, Chairman of The Mental Hygiene War Work Committee of The National Committee for Mental Hygiene is now on duty in the office of the Surgeon-General in charge of the neuro-psychiatric work in the army.

Major Thomas W. Salmon, Medical Director of the National Committee for Mental Hygiene, is on duty in the office of the Surgeon-General.

Over 260 psychiatrists and neurologists have been commissioned in the Medical Reserve Corps and are now on duty in the various American camps weeding out recruits who are unfit for military duty because of neuropathic or psychopathic conditions.

Lieutenant Horatio M. Pollock, S.C., Statistician of the New York State Hospital Commission, is in charge of the statistical work in the division of neurology and psychiatry in the office of the Surgeon-General.

Psychopathic wards have been provided in the base hospitals at Camp Devens, Ayer, Massachusetts; Camp Upton, Yaphank, Long Island,

New York; Camp Dodge, Des Moines, Iowa; Fort Sam Houston, Texas; and Fort McPherson, Georgia. The Psychopathic Hospital at Camp Devens is in command of Major L. Vernon Briggs, formerly Secretary of the Massachusetts State Board of Insanity. Major Briggs is assisted by Captain Douglas A. Thom of the Grafton State Hospital and Captain Morgan Brewster Hodskins of the Monson State Hospital. At Camp Upton, Major Graeme M. Hammond of New York City is in command, assisted by Captain A. J. Rosanoff of the Kings Park State Hospital and Lieutenant Richard S. Pearse of New York City. The hospital at Camp Dodge is under the direction of Captain Edmund M. Baehr of Cincinnati. Lieutenant D. E. Singleton, formerly Assistant Superintendent, State Hospital No. 1, Fulton, Missouri, and Lieutenant Philip Work of Denver, Colorado, are on duty at this hospital. Captain Gordon Fay Willey of the Kalamazoo State Hospital and Lieutenant Paul R. Sheppard of San Antonio, Texas, are on duty at Fort Sam Houston. Captain Earl D. Bond of the Pennsylvania Hospital, Philadelphia, is in charge of the neuro-psychiatric work at the base hospital, Fort McPherson, assisted by Lieutenant K. M. Bowman of the Bloomingdale Hospital and Lieutenant Victor J. P. Jourdan. Each of these hospitals has been built in accordance with specially prepared plans and each is well equipped with hydrotherapeutic, electrotherapeutic and other apparatus necessary for the proper care and treatment of patients suffering from nervous and mental disease. Neuro-psychiatric wards are being constructed at each of the cantonments as a part of each base hospital.

Lieutenant Dudley C. Kalloch, formerly an assistant in the Psychiatric Clinic at Sing Sing Prison, is on duty at Camp Lee, Petersburg, Virginia.

Lieutenant Francis M. Shockley, formerly an assistant at the Psychiatric Clinic at Sing Sing Prison and more recently Director of the Psychiatric Clinic at the Westchester County Penitentiary, and Lieutenant J. P. Eidson of the Henry Phipps Psychiatric Clinic, Johns Hopkins Hospital, Baltimore, are in charge of the psychiatric examinations at Camp Sevier, Greenville, South Carolina.

Captain Samuel Leopold of Philadelphia and Lieutenant H. A. Reye, formerly of the State Psychopathic Hospital, Ann Arbor, and the Pontiac State Hospital, Michigan, are on duty at Camp Wadsworth, Spartanburg, South Carolina.

Major R. M. Van Wart of New Orleans, Captain Jesse M. W. Scott, formerly of the Matteawan State Hospital, Lieutenant W. I. Lillie of the State Psychopathic Hospital, Ann Arbor, and Lieutenant Milford Levy of New York City are on duty at Camp Sheridan, Montgomery, Alabama.

Major George B. Campbell of the Utica State Hospital is in charge of the neuro-psychiatric work at the base hospital, Camp Pike, Arkansas.

Lieutenant Harold W. Wright of San Francisco, formerly of the Manhattan State Hospital, is on duty at Camp Kearney, Linda Vista, California.

Lieutenant E. A. Strecker of the Pennsylvania Hospital, Philadelphia, is on duty at Camp Hancock, Augusta, Georgia.

Captain Egbert W. Fell, formerly of the Boston Psychopathic Hospital, and more recently of the Elgin State Hospital, is in charge of the psychiatric examinations at Camp Grant, Rockford, Illinois.

Lieutenant R. M. Chambers of the Westboro State Hospital is directing the work of the psychiatric clinic at the Disciplinary Barracks, Fort Leavenworth, Kansas. This is the clinic organized by Major Edgar King, U.S.A., now on duty in the office of the Surgeon-General.

Major Milton Board of Louisville, Kentucky, Captain Morris J. Karpas, Director of the Psychopathic Clinic at the Children's Court, New York City, and Lieutenant Earl Moorman of the Central Indiana State Hospital, Indianapolis, compose the personnel of the psychiatric unit at Camp Zachary Taylor, Louisville, Kentucky.

Captain Mortimer W. Raynor, Clinical Director of the Manhattan State Hospital, and formerly Director of the Psychiatric Clinic at the New York City Prison, Blackwell's Island, is in charge of the examining at Camp Meade, Annapolis Junction, Maryland.

Captain Frank D. Ferneau, formerly of the Toledo State Hospital, has under his direction the psychiatric work at Camp Custer, Battle Creek, Michigan.

The psychiatric examining at the Recruit Depot, Jefferson Barracks, St. Louis, is under the direction of Lieutenant James F. McFadden, formerly of the Boston Psychopathic Hospital, more recently an assistant physician at the Foxborough State Hospital.

The work at Camp Shelby, Hattiesburg, Mississippi, is in charge of Lieutenant Robert F. Zimmerman of the Psychopathic Laboratory, Police Department, New York City.

Major E. Stanley Abbot, who has been in charge of the psychiatric examining at the Officers' Training Camp, Fort Snelling, Minnesota, has been ordered to Camp Sherman, Chillicothe, Ohio, where he will be in command of the psychiatric unit.

Major Menas S. Gregory, Director of the Psychiatric Clinic at Bellevue Hospital, New York City, has had under his supervision the special examinations at the Plattsburg Officers' Training Camp.

Major H. A. Cotton, Superintendent of the New Jersey State Hospital at Trenton, is in command of the neuro-psychiatric unit at Camp Dix, Wrightstown, New Jersey.

Captain E. G. Zabriskie of New York City conducted the special examinations at the Officers' Training Camp at Fort Niagara, New York.

Lieutenant Paul V. Anderson of Richmond, Virginia, and Lieutenant A. P. Chronquest of the Danvers State Hospital are on duty at Camp Green, Charlotte, North Carolina.

The psychiatric work at the Recruit Depot, Columbus Barracks, Columbus, Ohio, is under the direction of Captain E. L. Hanes of Rochester, New York.

Lieutenant Thomas J. Heldt of the Manhattan State Hospital and Lieutenant Harry R. Hoffman of Chicago are on duty at Camp Doniphan, Fort Sill, Oklahoma.

Major Richard H. Hutchings, Superintendent of the St. Lawrence State Hospital, is in command of the psychiatric unit at Camp Jackson, Columbia, South Carolina.

Major John H. W. Rhein of Philadelphia and Lieutenant George A. MacIver, formerly of the Boston Psychopathic Hospital, are on duty at Camp Travis, San Antonio, Texas.

Lieutenant George H. Preston of the Henry Phipps Psychiatric Clinic, Johns Hopkins Hospital, is on duty at Camp McArthur, Waco, Texas.

Major Ross Moore of Los Angeles, California, is in charge of the psychiatric work at Camp Lee, Petersburg, Virginia.

Captain Sanger Brown, II, of the Bloomingdale Hospital is on duty in the office of the Surgeon-General, division of neurology and psychiatry.

Major Arthur H. Ruggles of the Butler Hospital, Providence; Major Michael J. Thornton of the Psychiatric Clinic, Bellevue Hospital, New York; Captain Frederick W. Parsons, Hudson River State Hospital, Poughkeepsie; Captain Samuel W. Hamilton, Director of the Psychopathic Laboratory, Police Department, New York City; Captain Roscoe W. Hall, Henry Phipps Psychiatric Clinic, Johns Hopkins Hospital, Baltimore; Lieutenant James H. Huddleson, New York Neurological Institute; and Lieutenant J. M. Wolfsohn of San Francisco are in England studying in the hospitals for war neuroses.

Captain Jau Don Ball of San Francisco is in charge of the psychiatric examining at the Presidio.

The psychiatric examinations at Camp Gordon, Atlanta, Georgia, are under the direction of Major Eugene D. Bondurant of Mobile, Alabama.

Lieutenant Louis V. Lopez of New Orleans is on duty at Camp Gordon, Atlanta, Georgia.

Lieutenant Clifford W. Mack, formerly of the Pontiac State Hospital, Michigan, is in charge of the psychiatric examining at the Recruit Depot, Fort McDowell, California.

Psychiatric examinations are being made at the Naval Training Stations in Newport, Rhode Island, Norfolk, Virginia, Chicago and San Francisco. Lieutenant George F. Brewster of the Psychopathic Laboratory, Police Department, New York City, is in charge at Newport; Lieutenant Louis E. Bisch, formerly of the same laboratory, at Norfolk; Lieutenant H. S. Hulbert of the State Psychopathic Hospital, Ann Arbor, at Chicago; and Lieutenant A. Warren Stearns of the Boston Psychopathic Hospital, at San Francisco.

Lieutenant Arnold L. Jacoby, First Assistant Physician, State Psychopathic Hospital, Ann Arbor, has been detailed to duty at the Naval Disciplinary Barracks, Portsmouth, New Hampshire.

Courses in military neuro-psychiatry have been established at the St. Elizabeths Hospital, Washington, D. C., Dr. William A. White, Director; the State Psychopathic Hospital, Ann Arbor, Michigan, Dr. Albert M. Barrett, Director; the Boston Psychopathic Hospital, Dr. E. E. Southard, Director; New York Neurological Institute, Major Joseph Collins, Director; the Psychiatric Institute, Ward's Island, New York, Dr. George H. Kirby, Director; the Philadelphia General Hospital, Dr. T. H. Weisenburg, Director; the Henry Phipps Psychiatric Clinic, Johns Hopkins Hospital, Baltimore, Dr. Adolf Meyer, Director.

The classification of mental diseases, adopted by the American Medico-Psychological Association at its meeting in May, has been adopted by the Surgeon-General for use in the United States Army.

Psychiatric and Neurological Examination of Recruits

In detailing psychiatrists and neurologists to special duty with the armies, the Surgeon-General has had in mind (1) the proper care and treatment of soldiers who become incapacitated through mental or nervous disease (2) the special examination of recruits in the training camps in order that those who are unfit for military duty, because of neuropathic or psychopathic conditions, may be identified and discharged from service.

Until the troops move abroad the chief and most important responsibility of the military psychiatrists and neurologists will be the special examination of recruits. It is obvious that no man should be eliminated

who is fit to render a valuable service in this emergency. On the other hand, it is quite apparent that individuals suffering from certain forms of nervous and mental diseases should not be permitted to enter into service, as experience with the American armies has shown quite conclusively that such individuals are not capable of military service even in time of peace, and experience in the European armies has shown beyond question that such individuals are not able to withstand the rigors of modern warfare. At critical times such individuals go to pieces, with the result that the military force is weakened, is hampered in the free performance of its function, and the government is likely to be burdened after the war with the care of a large number of invalids.

After careful consideration the Surgeon-General has decided that the following general outline shall be followed in determining the recruits to be excluded because of neuropathic or psychopathic conditions. As it is important that the potential as well as the actual condition of the recruit be kept in mind, emphasis has been laid upon the early symptoms of disease. Likewise, attention has been called particularly to those diseases which are most likely to be met and which have not very obvious symptoms but which, nevertheless, can be diagnosticated relatively easily and with considerable certainty. It is not to be assumed that other neuropathic and psychopathic conditions when found are not cause for exclusion. Most of these, however, such as multiple neuritis, various forms of paralysis, hemiplegia, cranial nerve palsies and peripheral neuritis, have such striking symptoms that they are likely to be recognized before they come to the attention of the neurologists and psychiatrists.

RECRUITS TO BE EXCLUDED

I. Nervous Diseases

(a) *On the Basis of Disease*

1. Tabes. (Look for Argyll-Robertson pupils, absent knee and ankle jerks, ataxia of station and gait.)
2. Multiple Sclerosis. (Look for absent abdominal reflexes, nystagmus, intention tremor.)
3. Progressive Muscular Atrophy and Syringomyelia. (Look for fibrillary tremors; atrophy in the small muscles of the hand and of the muscles of the shoulder girdle; scars on forearm and fingers caused by burning; deformities of feet.)
4. Epilepsy. (Look for deep scars on tongue, face and head; voice. Where diagnosis depends only upon history of epileptic attacks given by the patient, the latter should be asked to give the address of the physician who has treated him. This history must then be verified by a letter from the physician.)
5. Hyperthyroidism. (Look for persistent tachycardia, exophthalmos, tremor, enlarged thyroid.)

(b) *On the Basis of Symptoms or Combination of Symptoms or History*

1. Unequal pupils+irregular pupils+Argyll-Robertson pupils.
2. Nystagmus (in one not an albino)+absent abdominal reflexes+intention tremor.
3. Absent knee jerks associated with some one other organic neurologic symptom.

4. Exaggerated tendon jerks+Babinski.
5. Disorders of station or gait.
6. Disorders of speech (on test phrases)+facial tremor+one other organic neurologic symptom. (Stammering and stuttering *per se* is not significant of an organic neurologic condition. Stammerers and stutterers are rejected by regulations. See form No. 94777.)
7. History of Epilepsy. (Ask the recruit to give the address of the physician who has attended him; this information to be verified by letter.)

II. Mental Diseases

(a) *On the Basis of Disease*

1. General Paralysis. (Look for Argyll-Robertson pupils, speech defect consisting of distortion of words, writing defect consisting of distortion of words, facial tremor in showing the teeth, euphoria and marked discrepancies in giving facts of life.)
2. Dementia Praecox. (Look for indifference, ideas of reference, feelings of the mind being tampered with (*e. g.* ideas of hypnotism), auditory hallucinations, bodily hallucinations such as electrical sensations or sexual sensations, meaningless smiles; in general, inappropriate emotional reactions, lack of connectedness in conversation.)
3. Manic Depressive Insanity. (Look for mild depressions with or without feeling of inadequacy or mild manic states with exhilaration, talkativeness and overactivity.)

(b) *On the Basis of Symptoms or Combination of Symptoms or History*

History of previous mental illness. (Ask the recruit to state when and where he had such illness, in what hospital he was observed or treated or by what physician he was attended; this information to be verified by letter.)

III. Psychoneuroses and Psychopathic Characters

Look for phobias, morbid doubts and fears, anxiety attacks, fatigability, hypochondriasis, compulsions, homosexuality, grotesque lying, vagabondage.

IV. Chronic Alcoholism

Look for suffused eyes, prominent superficial blood vessels of the nose and cheeks flabby, bloated, reddened face, purplish discoloration of the mucous membrane of the pharynx and of the soft palate; also ashen complexion and clammy skin; muscular tremor in the protruded tongue and extended fingers (noticeable also in lack of control when the applicant attempts to sign his name); emotionalism, prevarication, suspicion; auditory or visual hallucinations, paranoid ideas.

V. Mental Deficiency

Look for defect in general information with reference to native environment, ability to learn, to reason, to calculate, to plan, to construct, to compare, weights, sizes, etc.; defect in judgment, foresight, language, output of effort, suggestibility, stigmata of degeneration, muscular incoordination. (Consult psychometric findings.)

VI. Drug Addiction

Look for pallor, dryness of skin; flippancy, mild exhilaration (if under the influence); cowardly, cringing attitude, restlessness, anxiety (if without drug); distortion of the alae nasi; contracted pupils (morphine) or dilated pupils (cocaine); dirty deposit at junction of gums and teeth; bluish and whitish needle scars on thighs and arms.

The attention of line officers has been called to the fact that certain personality traits are of importance as indicative of possible underlying mental conditions, and the officers

have been asked to refer to the psychiatrists the following recruits: Irritable; seclusive; sulky; depressed, shy, timid; over boisterous; sleepless; persistent violators of discipline; "queer sticks," cranks; "goats"—butts of practical jokes; "boobs"—those who have difficulty in comprehending orders—dull, stupid; those with marked emotional reaction (such as vomiting and fainting) at bayonet drill; those with peculiarities of attitude, speech or behavior sufficiently marked to attract attention of associates; those resentful of discipline; suspicious; sleep walkers; bed wetters; those persistently slovenly in dress; those who have difficulty in executing muscular movements in setting-up exercises.

Reclamation of Discharged Conscripts

It is important that conscripts discharged for physical reasons be not thrust back into civil life without guidance or instruction as to their needs. In order that such conscripts may be reclaimed for possible future military service, or that at least their efficiency be increased for civil life, and thus the general health of the community and the background of military defense improved to that degree, the General Medical Board of the Council of National Defense has under consideration a plan that calls for the co-operation of the Medical Corps of the Army, the State Committees and Auxiliary Medical Defense Committee, Medical Section, Council of National Defense and certain national organizations.

It is planned that all conscripts rejected by exemption boards for military service, and all conscripts rejected at the cantonments, and all rejected volunteers, shall receive a standard leaflet entitled, "How to Become Physically Fit: Information for Guidance and Assistance of Those Rejected for Military Service," prepared by the General Medical Board of the Council of National Defense, covering the following salient features:

a. Urgent need of giving attention to defects, in interest of self and country.

b. Brief, terse explanation of the principal causes of rejection to be given, and instructions as to significance and measures of relief; importance of medical or surgical treatment, and measures of personal hygiene for improving the conditions found.

c. Discharged conscripts to be urged to seek advice from the Secretary of the Auxiliary Medical Defense Committee of the county of residence as to the best method of procedure for improving their condition and utilizing to the full the knowledge of their impairment.

d. State and Auxiliary County Committees will be requested to accumulate data as to the local facilities for relief and education of these impaired lives and will guide them to the best available channels of relief.

e. Other possible sources of advice and assistance named in the leaflet are: family physician; local hospitals or dispensaries; Y. M. C. A. branches; local medical society; local health department or local health officer; national and local associations for prevention of special diseases —tuberculosis, mental and nervous diseases, cancer—such as

National Association for the Study and Prevention of Tuberculosis, 102 East 22nd Street, New York City. (Instruction and guidance as to best procedure.)

The National Committee for Mental Hygiene, 50 Union Square, New York City. (Advice and suggestions for procedure in nervous and mental cases.)

The American Social Hygiene Association, 105 West 40th Street, New York City. (Advice on social hygiene; best course to follow for cure of disease.)

The American Society for Control of Cancer, 25 West 45th Street, New York City. (Advice and guidance.)

Y. M. C. A. Local Branches. (Physical training, lectures, advice and guidance.)

Health Department, State and Local. (Treatment in some cases, advice and guidance.)

Life Extension Institute, 25 West 45th Street, New York City. (Educational material on keeping well, hygiene, physical examination, report and guidance.)

Special instruction as to communication with these societies and the possible aid to be derived is included.

All rejected conscripts can be to some extent improved even though they may not be made eligible for military service, and this holds good for every citizen.

Contact with these discharged conscripts and the public interest in the vitality of the nation aroused by the draft examinations, should be utilized to the full, and the message of hygienic living carried as far and wide as possible.

Mental Hygiene War Work Committee

The personnel of The Mental Hygiene War Work Committee of The National Committee for Mental Hygiene is as follows:

Chairman, Major Pearce Bailey, Chief of Service, New York Neurological Institute, New York City

Vice-Chairman, Dr. Frankwood E. Williams, Associate Medical Director, The National Committee for Mental Hygiene, New York City

Dr. Felix Adler, New York Society for Ethical Culture, New York City

Mr. Otto T. Bannard, New York City

Dr. Lewellys F. Barker, Johns Hopkins University Medical School, Baltimore, Maryland

Dr. Albert M. Barrett, Director, State Psychopathic Hospital, Ann Arbor, Michigan

Dr. G. Alder Blumer, Superintendent, Butler Hospital, Providence, Rhode Island

Major L. Vernon Briggs, formerly Secretary, Massachusetts State Board of Insanity, Boston, Massachusetts

Dr. C. B. Burr, Superintendent, Oak Grove Hospital, Flint, Michigan
Dr. Nicholas Murray Butler, President, Columbia University, New York City
Major Joseph Collins, Chief of Service, New York Neurological Institute, New York City
Dr. Owen Copp, Superintendent, Pennsylvania Hospital, Philadelphia, Pennsylvania
Dr. Charles L. Dana, Chief of Service, New York Neurological Institute, New York City
Dr. Walter E. Fernald, Superintendent, Massachusetts School for the Feebleminded, Waverley, Massachusetts
Dr. Shepherd I. Franz, Psychologist, St. Elizabeths Hospital, Washington, D. C.
Major M. S. Gregory, Director, Psychopathic Clinic, Bellevue Hospital, New York City
Dr. Isham G. Harris, Superintendent, Brooklyn State Hospital, Brooklyn, New York
Dr. August Hoch, formerly Director, Psychiatric Institute, Ward's Island, New York City
Dr. George H. Kirby, Director, Psychiatric Institute, Ward's Island, New York City
Dr. Adolf Meyer, Director, Henry Phipps Psychiatric Clinic, Johns Hopkins Hospital, Baltimore, Maryland
Dr. Frank P. Norbury, formerly Alienist of the Illinois State Board of Administration, Jacksonville, Illinois
Dr. Stewart Paton, Lecturer on Neuro-biology, Princeton University, Princeton, New Jersey
Mrs. Henry Phipps, New York City
Dr. William L. Russell, Superintendent, Bloomingdale Hospital, White Plains, New York
Major Thomas W. Salmon, Medical Director, The National Committee for Mental Hygiene, New York City
Dr. E. E. Southard, Director, Psychopathic Hospital, Boston, Massachusetts
Dr. T. H. Weisenburg, President, American Neurological Association, Philadelphia, Pennsylvania
Dr. William A. White, Superintendent, St. Elizabeths Hospital, Washington, D. C.
Major Robert M. Yerkes, Professor of Psychology, University of Minnesota, Minneapolis, Minnesota.

The American Medico-Psychological Association at its annual meeting in June adopted a resolution, directing the president to appoint one member of the Association in each state to co-operate with The Mental Hygiene War Work Committee of The National Committee for Mental Hygiene. The following members were appointed:

Alabama	Dr. J. T. Searcy, The Bryce Hospital, Tuscaloosa
Arizona	Dr. Alfred C. Kingsley, Arizona State Hospital, Phoenix
Arkansas	Dr. James L. Green, Hot Springs
California	Dr. Jau Don Ball, Oakland
Colorado	Dr. Hubert Work, Woodcroft Hospital, Pueblo
Connecticut	Dr. C. Floyd Haviland, Connecticut State Hospital, Middletown
Delaware	Dr. W. H. Hancker, Delaware State Hospital, Farnhurst
District of Columbia	Dr. William A. White, St. Elizabeths Hospital, Washington
Florida	Dr. Ralph N. Greene, Chattahoochee
Georgia	Dr. Wm. A. Ellison, Invalid's Home, Milledgeville
Idaho	Dr. John W. Givens, Idaho Northern Asylum, Orofino
Illinois	Dr. Henry J. Gahagan, State Hospital, Elgin
Indiana	Dr. S. E. Smith, Eastern Indiana Hospital, Richmond
Iowa	Dr. W. P. Crumbacker, Independence State Hospital, Independence
Kansas	Dr. Thomas Biddle, Topeka State Hospital, Topeka
Kentucky	Dr. H. P. Sights, Paducah
Louisiana	Dr. Clarence Pierson, East Louisiana Hospital, Jackson
Maine	Dr. Forrest C. Tyson, Augusta State Hospital, Augusta
Maryland	Dr. Edward N. Brush, Sheppard and Enoch Pratt Hospital, Towson
Massachusetts	Dr. Henry R. Stedman, Bournewood Hospital, Brookline
Michigan	Dr. C. B. Burr, Oak Grove Hospital, Flint
Mississippi	Dr. J. M. Buchanan, East Mississippi Insane Hospital, Meridian
Missouri	Dr. C. R. Woodson, St. Joseph
Montana	Dr. J. M. Scanland, Montana State Hospital, Warm Springs
Nebraska	Dr. W. S. Fast, Nebraska State Hospital, Ingleside
New Hampshire	Dr. Charles P. Bancroft, New Hampshire State Hospital, Concord
New Jersey	Dr. Henry A. Cotton, New Jersey State Hospital, Trenton
New York	Dr. Charles G. Wagner, Binghamton State Hospital, Binghamton
North Carolina	Dr. Isaac M. Taylor, Broadoaks Sanatorium, Morganton
North Dakota	Dr. W. M. Hotchkiss, State Hospital, Jamestown
Ohio	Dr. E. A. Baber, Dayton State Hospital, Dayton
Oklahoma	Dr. John Williams Duke, Duke Sanitarium, Guthrie
Oregon	Dr. Henry Waldo Coe, Morningside Hospital, Portland
Pennsylvania	Dr. Henry A. Hutchinson, Dixmont Hospital, Dixmont
Rhode Island	Dr. G. Alder Blumer, Butler Hospital, Providence
South Carolina	Dr. C. F. Williams, State Hospital, Columbia
South Dakota	Dr. L. C. Mead, Yankton State Hospital, Yankton
Tennessee	Dr. James J. Neeley, Memphis
Texas	Dr. John Preston, State Lunatic Asylum, Austin
Utah	Dr. George E. Hyde, Utah State Mental Hospital, Provo City
Vermont	Dr. Shailer E. Lawton, Brattleboro Retreat, Brattleboro
Virginia	Dr. William F. Drewry, Central State Hospital, Petersburg
Washington	Dr. Robert P. Smith, Seattle
West Virginia	Dr. Charles A. Barlow, Spencer State Hospital, Spencer
Wisconsin	Dr. Richard Dewey, Milwaukee Sanitarium, Wauwatosa
Wyoming	Dr. Charles H. Solier, State Hospital, Evanston

At the annual meeting of the American Neurological Association, a War Work Committee, composed of Dr. E. E. Southard, Chairman, Dr. T. H. Weisenburg, Dr. Charles Frazier and Dr. Daniel J. McCarthy, was likewise appointed to co-operate with The National Committee for Mental Hygiene.

In Massachusetts a Committee for War Work in Neurology and Psychiatry, appointed by Governor McCall and composed of Dr. George M. Kline, Chairman, Dr. L. Vernon Briggs, Dr. John A. Houston, Dr. Walter E. Fernald, Dr. Elisha H. Cohoon, and Dr. James B. Ayer, is also co-operating.

The initial work of The War Work Committee of The National Committee for Mental Hygiene was made possible through a generous gift made by Miss Anne Thompson of Philadelphia, daughter of the late Frank Thompson, formerly President of the Pennsylvania Railroad.

The Sub-committee on Clinical Methods and Standardization of Examinations and Reports of The Mental Hygiene War Work Committee of The National Committee for Mental Hygiene is as follows: Dr. August Hoch, Chairman; Major Pearce Bailey, Washington; Dr. Albert M. Barrett, Ann Arbor; Major Joseph Collins, New York City; Dr. Walter E. Fernald, Waverley; Dr. George H. Kirby, New York City; Dr. Adolf Meyer, Baltimore; Major Thomas W. Salmon, Washington; Dr. E. E. Southard, Boston; Dr. T. H. Weisenburg, Philadelphia; Dr. William A. White, Washington; Dr. Frankwood E. Williams, New York City; Major Robert M. Yerkes, Washington.

Neurological centers have been established both by the French and English War Departments immediately behind the fighting line. Here quick returns are the order of the day. According to Colonel Sir John Collie, the atmosphere in which the shell-shocked soldier is treated is second only in importance to the personality of those who are to treat him. In these front-line neurological centers the treatment is more intensive, but the feature which distinguishes it from the means employed at home is that the cases are taken, as it were, red-hot from the battlefield, and are moulded by the strong will of those specially selected for their treatment. Frequently men are returned to the fighting line in two or three weeks. (Contrast this with the unfortunate experience of those who find themselves for a period extending to even twelve months in some eight or nine different hospitals, perhaps some of them V. A. D. hospitals.)

There is a special shock hospital for each army area. They are placed near the clearing hospitals, and are staffed by specially selected medical officers under the superintendence of a neurologist of repute. Here the case is thoroughly investigated, and, if it is found that the man is not likely to recover soon, he is sent to a base hospital, from which in time he may be transferred to England. Numbers of men treated at these special hospitals are found after one, two or three weeks' treatment to have sufficiently recovered to be transferred to a local convalescent camp, where attention is specially paid to them as convalescent neurasthenics. Appropriate exercises are prescribed and, later on, football and competitive games of skill are encouraged.

BOOK REVIEWS

TRUANCY AND NON-ATTENDANCE IN THE CHICAGO SCHOOLS. A Study of the Social Aspects of the Compulsory Education and Child Labor Legislation of Illinois. By Edith Abbott, Ph.D., and Sophonisba P. Breckinridge, Ph.D. Chicago: The University of Chicago Press, 1917.

This book is an outgrowth of some work which began as a study of the delinquent children at the Juvenile Court of Chicago. The study of the truant and dependent children led the authors into the larger problem of school attendance and an investigation of the operation of the child labor laws. The first part of the book reviews the legal aspect of compulsory education and the gradual development in Illinois of legislation safeguarding the children from industrial exploitation and providing educational opportunities for them. The second part of the book deals with the extent of truancy and non-attendance in Chicago and sets forth the results of the study of the reasons for non-attendance. The authors emphasize the fact that this is a home problem and not one which can be solved merely by a study of the children, or the schools, or the teachers.

The parental school was found to have done excellent work and to have been much appreciated by the parents. On the other hand, the parental school is so costly that its equipment should not be used except for cases that cannot be handled otherwise, and attention to truancy at its source in the home might in many cases lead to a more economical handling of the situation and spare the parents the distress of separation.

The authors recommend that school visitors or visiting teachers should supplement the work done by the officers of the department of compulsory education. They give many convincing examples to show how useful such workers would be.

In a chapter devoted to the summary and conclusions, the authors outline the various statutory changes which they feel would increase very greatly the efficiency of the educational system in Chicago. Their suggestions include among others that the age of lawful employment of children be raised to 14 or 16 years, that the issuing of working papers, now the duty of the local school superintendents, be made a function of the state department of education, and that these working papers should be issued under more stringent restrictions than at present. Provision should also be made for special continuation schools.

The book does not deal with the individual truant but rather with the social aspects of the situation. Nevertheless, the authors in the course of their discussion show that they have excellent insight into the needs of the individual child. The book is well arranged, the subject matter is

systematically presented, and the results of a very thorough and painstaking investigation are formulated in a manner which enhances their value.

C. MACFIE CAMPBELL.

GENETICS AND EUGENICS. By W. E. Castle. Cambridge: Harvard University Press, 1916.

The author has essayed to present in a simple and readily intelligible form the subject of heredity in man and the domesticated animals and plants. The history of evolutionary theory is briefly sketched, a chapter each being devoted to biometry, to the mutation theory and to Mendel's law. Some applications and later developments of Mendel's law are set forth, and then five chapters are devoted to unit characters in various groups of animals. The recent demonstration that the germinal determiners for characters lie serially arranged in the chromosomes, and the facts of sex-linked inheritance are treated in three chapters; and the question of the variability of unit characters and the universal applicability of the theory of discrete units in heredity are discussed in three chapters more. Finally about 45 pages are devoted to heredity in man.

In many respects Castle's book has achieved his aim. It is well written, illustrated by 135 figures and a colored plate, is accompanied by a bibliography of 25 pages and a translation of Mendel's famous paper, and is published in the best fashion. To every one who wants a readable account of progress in modern genetics this book may be recommended. Yet the writer feels that it has certain clear limitations. The first arises from a failure to clear the boards at the outset of the rubbish of popular nomenclature and false ideas about heredity that have come to us from an earlier time. It is not a concession to didactic needs but an admission of a sort of intellectual inertia to speak of "the influence which parents exert on the characteristics of their offspring" (p. 3) as the main scope of genetics. Now the only influence that any parent exerts on its offspring is as *nurse;* and this influence is not what is meant by heredity.

Unfortunate, also, is Castle's use of "Mendelian" as a name for modern genetical analysis. It is clear that modern genetics has gone far beyond anything that Mendel conceived. There is no desire to belittle Mendel's part in laying the foundation for modern genetics, but it is as unfortunate to speak of Mendelian heredity as of Hippocrotean medicine or Galenical anatomy for these sciences in their modern development.

Equally unfortunate for clear thinking is the rejection by the author of distinct terms for somatic traits and the germinal "determiners" ("factors," "genes") out of which they develop. If the "unit characters" about which we talk are the "hypothetical determiners," then we would do well to abandon the term unit character, and recognize that we have

characters—like eye color—that depend on *one* determiner; others, like negro skin color, that depend on two similar determiners and others, like some kinds of hair color, that depend on two or more dissimilar determiners. Perhaps we need a new term for somatic characters that have a tested *genetic* basis; we might call them *somates*. Then we would recognize simple somates, compound somates, and complex somates according to the demonstrated genetic composition.

For readers of MENTAL HYGIENE, Castle's attitude toward eugenics will be of especial interest. Reference may be made first to Castle's criticism that the method of collecting data at the Eugenics Record Office is biased by Mendelian prejudices. Such a charge can be based only on entire ignorance of how the data are collected; the criticism is only a faint echo of the Pearson-Heron outpouring of "spleen" (*epinephrin*) which certainly was not based on first-hand knowledge. One might just as well reject all anamneses on the ground that the physician who took them had been trained in psychiatry! After reviewing some of the findings on heredity of human traits, Castle discusses "The Possibility and Prospects of Breeding a Better Human Race." Here he quotes at length, with apparent approval, from Cattell's study of the families of 1,000 American men of science. But Cattell lays rather more emphasis on "circumstances" in producing the result than a more complete analysis of the facts seems to warrant. It is by co-operation of the rifle barrel and the charge that the steel bullet is propelled a mile in nearly a straight line. It is natural that the arms maker should lay stress on the importance of the gun barrel and that the munitions maker should lay stress on the explosive charge. Both are just as important as possible and it is foolish to try to minimize either. Sociologists have in the past erred grossly by assuming that persons are born equal and that the differences in their output are to be ascribed to conditions of life. Biologists may have over emphasized the determinative nature of the genes. In trying to avoid the latter error Castle has, we think, leaned too far backward.

C. B. DAVENPORT.

DER ANGEBORENE SCHWACHSINN IN SEINEN BEZIEHUNGEN ZUM MILITÄRDIENST. By Theophil Becker. Berlin, 1910.

EXPERTISE PSYCHIATRIQUE DANS L'ARMÉE. (In Précis de Psychiatrie.) By E. Régis. 5th ed. Paris, 1914.

MILITARY PSYCHIATRY. By R. L. Richards, Captain, Medical Corps, United States Army. American Journal of Insanity, July, 1910.

A review of these books—which are not of very recent publication—is undertaken here because they deal with a subject that has assumed an unwonted importance for us since this country has become involved in the great war.

In armies, as in civil life, an apparent, progressive increase of mental disorders has been observed for a number of decades past. This is now generally attributed to the gradually developed, more exacting standard of living and service, increased hospital facilities, and improved methods of diagnosis and observation. The increase is well shown in the German army statistics cited by Becker, from which the following figures have been abstracted:

Fiscal years	1874–75	1879–80	1884–85	1889–90	1894–95	1899–00	1904–05
Cases of mental trouble per 1,000 of effective strength..	0.21	0.28	0.33	0.35	0.48	0.60	1.10

It may be noted, in passing, that even the more recent statistics represented in this table show a striking rarity of mental disorders in contrast with corresponding statistics for the armies of the Allies during the present war. But it must be remembered, on the one hand, that the German army has long taken special pains to exclude mentally abnormal persons, and, on the other hand, that the incidence of mental disorder in armies in times of peace is lower than in times of war.

Mental cases in the German army, reported in the fiscal year 1905–1906, total number 1,190, have been classified, according to Becker, essentially as follows:

	Per cent
Mental deficiency	51.7
Dementia praecox	17.1
Constitutional psychopathics	8.4
Epilepsy	5.8
Manic-depressive psychoses	5.6
Acute hallucinatory states	3.4
Hysterical psychoses	2.5
Paranoia	1.5
General paresis	1.0
Alcoholic psychoses	0.6
Traumatic psychoses	0.5
Unclassified	1.9

A significant point made by Becker pertains to the progressively diminishing rate at which psychiatric cases were brought to light in the four quarters of the first year of military service: 37.8 per cent in the first quarter, 28.2 per cent in the second, 21.6 per cent in the third, and 12.4 per cent in the fourth.

In the army, as in civil life, psychiatrists are not infrequently confronted with doubtful or borderline cases in which the question of permitting or not permitting continuance in the service presents special difficulties. The last and, at the same time, the most trustworthy test in such cases is that of further service; of six cases mentioned by Becker,

provisionally classed as fit and returned for such test, three eventually remained in service and three were discharged as unfit.

A large part of the book is devoted to methods of investigation and diagnosis all of which are borrowed from current civilian psychiatry. A great point is made of examining all cases showing striking defects or peculiarities of writing, either in content or in form; and a further point is made of the need of provision for detention of patients for psychiatric observation.

Turning to Régis' book, we find equally clear recognition of the need of psychiatric service in armies and navies based on extensive experience represented by a number of studies referred to in the text. It was such recognition that led, early in 1913, to the issuance of an official bulletin by the French War Department providing for: "1. Psychiatric instruction of army surgeons. 2. Army surgeons specialized in psychiatry. 3. The assignment to military organizations of specialists in psychiatry. 4. Psychiatric examinations for exemption boards. 5. Similar examinations in connection with voluntary enlistments, conscripting of troops, and in the course of service. 6. Expert consultation before court-martial."

A remarkable contrast is pointed out in the relative frequency of the various forms of mental alienation as occurring in officers and in enlisted men. "The most frequent mental affection among the officers is, by far, general paresis." Among enlisted men "degeneration" (constitutional disorders) predominates: unbalanced, eccentric, feeble-minded individuals, often presenting complications in the form of alcoholism, epilepsy, hysteria, neurasthenia, obsessions, dementia praecox, etc.

Régis approvingly cites the recommendation of Jacoby—growing out of experiences in the Russo-Japanese war and for the first time carried out during that war—that either psychiatric hospitals be established for use during campaigns at points conveniently accessible to the field of operations, or special pavilions in connection with field hospitals.

Richards, too, emphasizes the need not only of psychiatric service for armies in times of peace but also of special provision for the care of the greatly increased numbers of psychiatric cases in times of war, especially during active campaigns. "Psychiatrists (Oserezkowski and others) report that during the Russo-Japanese war they saw insane wandering about everywhere, in spite of the best psychiatric organization the world has ever seen. In one instance a whole regiment of Russians became infected with the fear that the Japanese having stopped their advance were about to open upon them with artillery fire. Officers and men ran as best they could for twenty-four hours, until checked by the main column. Psychic infection from the weaker ones seems the most reasonable explanation of this most remarkable occurrence. The large

number of hysterical and exhaustion psychoses observed by the Russians show us what preparations we must make in the event of a modern battle. We know of no means of preventing the presence of some psychical weaklings at such a time. Even if it be a fact that they recover promptly, it is also admitted that they are especially liable to a recurrence if placed again in the same circumstances."

It is the observation of all authors that a large proportion of cases of mental abnormality in military organizations come to light through delinquencies. Richards states: "Of 500 discharges of soldiers coming directly from the ranks to the Government Hospital for the Insane in the period 1860 to 1909, I find that 12.6 per cent were 'dishonorable,' or 'without honor' discharges, or had records of military offenses, chiefly desertion."

"The offenses recorded in the 500 discharges mentioned above, were as follows:

Desertion	49
Absence without leave	26
Assaulting officer or comrade	21
Fraudulent enlistment	8
Larceny	2
Selling clothing	1
False official statement	1
Disobedience of orders in war time	1
Embezzling	1
Rape	1
Disability, result of own misdeeds	7
Not specifically designated	20
Total	138"

It would seem clear from all this—even independently of the more significant, recent experiences—that military organizations can no longer afford to neglect their psychiatric problems in times of peace and that these problems assume a special magnitude and urgency in times of war, particularly during active campaigns.

The more specific indications are also quite clear:

1. Opportunities for large economies in time, labor, expense, and even human life are to be found in psychiatric service in connection with recruiting.

2. Similar opportunities are to be found in training, mobilization and concentration camps. In connection with such camps places of detention with proper equipment for psychiatric observation should be provided. An adequate force of psychiatrists and medical and lay assistants should be available for such work.

3. Continued provision for psychiatric service, subsequent to the periods of training and mobilization, should also constitute an integral part of the work of the medical corps.

4. Psychiatric pavilions should be provided in connection with field and base hospitals.

5. Psychiatric service should be made available for all cases of delinquency in military organizations.

6. Provision should be made for returning from the war zone to hospitals at home, under proper care and custody en route, of such mental cases as cannot be returned to the ranks.

A. J. ROSANOFF.

MORAL SANITATION. By Ernest R. Groves, Professor of Sociology, New Hampshire State College, Durham, N. H. New York: Association Press, 1916. 128 p.

This little book belongs to a class of literature which is constantly becoming more abundant and which emphasizes a very healthy attitude on the part of those people who desire knowledge about themselves that will be helpful in the practical problems of living.

Professor Groves hardly claims to have written a treatise on moral sanitation. His book is more of a running commentary or a collection of thoughts, designated as chapter headings, bound together by the comments of a man who has read widely and thought much over the problems of human conduct. He believes profoundly that in a scientific study of man's behavior ought to be found the principles upon which efficient living must be based and that these principles are to find their way into the highways and byways of social life, into the factory and be applied by the workman at his task, into the family and be applied by the parents in the education of their children, into the church and provide the reasons for its moral precepts, in fact, into every place where man's activities carry him. Professor Groves' attitude toward conduct is wholesome and constructive. He believes that a man is entitled to the privilege of wholesome work in which he finds self-expression and to the boon of happiness and that the really great social problems that confront us are perhaps the very ones of providing a means to these ends.

Professor Groves, like many another broad-minded man, has come to believe that the principles worked out by Freud and embodied in the methods of psychoanalysis can no longer be neglected by the moral teacher who desires to do the best that can be done, that the psychoanalytic principles, in other words, throw a light upon the springs of human conduct, which it is invaluable to know about if we are to improve our ways of living.

WILLIAM A. WHITE.

THE PSYCHOANALYTIC METHOD. By Oskar Pfister, translated by Charles R. Payne, M.D. New York: Moffat, Yard & Company, 1917. 588 p.

This work represents the most ambitious attempt that has been made to review thoroughly the whole psychoanalytic movement, particularly

its therapeutic aspect, in the light of personal experience. Pfister considers the subject in its various ramifications and details, both in theory and in practice, enriching it with a large amount of case material. Like all comprehensive works, it might be criticized here and there, but as a whole it is a monumental and valuable work. Credit should also be given to the translator for a difficult task well done.

The author is not a physician, but a pastor and a pedagogue and his primary interests radiate from these two viewpoints. His cases, therefore, are drawn largely from among children or young adults. To those who see in the psychoanalytic movement a moral menace this work should be an enlightenment, showing, as it does, the minister and the teacher going among his people and his children, helping them in their distress, using the principles and the technique of psychoanalysis, yet dominated by the highest religious and educational ideas.

The latter part of the work, in which the author deals specifically with the problems of religion and of education, is perhaps the happiest. He sees in the teachings of Jesus what he believes to be perfectly expressed truths and what the psychoanalysts have seen for many years, namely the articulate wisdom of the folk soul. His discussion of the problems of education should be read by the teachers and superintendents of every institution that cares for children. The ineffectualness of approaching the difficulties of children—or of adults, for that matter—solely at the conscious level needs to be emphasized again and again. This is particularly true in the matter of corporal punishment, which not only fails to convince the one on whom it is inflicted, but is liable to produce positive injury by creating emotional reactions which serve still further to cripple the individual in his dealings with reality. The book deserves a wide reading.

WILLIAM A. WHITE.

THE DEVELOPMENT OF INTELLIGENCE IN CHILDREN (The Binet-Simon Scale) and THE INTELLIGENCE OF THE FEEBLEMINDED. By Alfred Binet, Sc.D. and Th. Simon, M.D. Translated by Elizabeth S. Kite. Publications of the Training School at Vineland, New Jersey, Department of Research, Nos. 11 and 12. Baltimore: Williams and Wilkins Company, 1916.

These two volumes bring together a series of articles published by Binet and Simon in *L'Année Psychologique* during the years from 1905 to 1911 inclusive, and dealing with the development and application of the scale which bears their names. The first volume deals primarily with the development of the scale, while the second consists of discussions of mental development, defect, and disease in which the scale is utilized. The chronological arrangement is followed except that the contents of the second volume belong to the years 1908 and 1909 and therefore antedate the concluding paper of volume one.

The first three chapters treat of the 1905 tests. The situation which confronted the authors is described. Want of precision both in defining terms and in describing symptoms had resulted in a chaos of inconsistent findings and unreliable statistics, and made it impossible to determine the effect of any treatment. The history of the subject is taken up showing that while the problem is essentially psychological, the practical judgment of any particular individual was based upon medical symptoms and frequently upon non-essentials. The comments on Sollier's suggestion that defectives should be classified on the basis of attention is interesting in connection with the authors' own treatment of that topic in one of the later articles. Dr. Blin's program of examination is reproduced in full.

Before presenting their own series of tests, they carefully delimit the problem, both as to subjects and functions to be studied and as to methods to be employed. Their conception of a measuring scale is explained, and it is noticeable that the idea of groups of tests corresponding to different mental levels had already taken shape in their minds although the tests were not published in that form until three years later. The trying out of this first series with both normals and subnormals is described in considerable detail, showing how the various age groups were differentiated.

In Chapter IV we have the 1908 scale, where the tests first appear in groups corresponding to ages, and the first rules for computing mental age are laid down.

Chapter V gives the 1911 revision of the scale, the form in which it was left by Binet at his death. Other topics of practical interest are discussed, such as the relation of social and scholastic status to intellectual level; various criticisms are answered; and the "principle of multiplicity of tests" is emphasized.

The second volume opens with a discussion of the intelligence of the feebleminded under many aspects, and a "scheme of thought" is propounded.

Part II proposes "a new method of psychogenesis" by which defective subjects are to be utilized for prolonged or repeated experiments in which, if normal children were studied, the results would be vitiated by the fact that the mental status of the subject would not remain constant. The method is illustrated by a study of language development in an imbecile.

In Part III the feebleminded are compared with general paralytics and dements in considerable detail as regards the mental level, the functioning of the intelligence, and the instinctive and ideational aspects of mental life.

The multiplicity of details in these volumes and the very considerable repetitions are wearisome, but they are inevitable in such presenta-

tion of the subject. Departures from the customary phraseology constitute a difficulty which many readers will not find compensated by gain in clarity. Thus, "image" is apparently limited in meaning to visual and auditory imagery of the concrete type, "image" and "word" are opposed to each other, kinaesthesia is barely recognized, and "perception" is used to denote sensory discrimination. A further source of obscurity is the peculiarity of arrangement, or perhaps lack of arrangement, which occasionally makes it difficult to interpret the or to turn readily to a desired topic. At times, also, when a case is under discussion it is difficult to decide whether it is a case study or as typical of a group of individuals.

With all their difficulties, however, these volumes will be welcomed by many readers. The examiner will find much in the detailed presentation of individual cases, as well as critical recommendations. Whatever the present value of the Binet-Simon Scale, it should be seen in the light of its authors' intentions and against the background of the situation as they found it. Moreover, in science, as well as in industry, the by-products of one invention provide the material and the point of departure for the next, and these records abound in observations carefully noted but utilized imperfectly, or not at all, because not bearing directly upon the problem of the type of age-scale which these investigators had set themselves to construct. Even those who read French easily and have access to special libraries will be glad to have this material put into compact shape and made available for their own bookshelves.

ROSE S. HARDWICK.

HOSPITALS AND THE LAW. By E. V. Mitchell, LL.B. New York: The Rebman Company, 1915.

The author reviews briefly the history of hospital development discussing the institution from a legal viewpoint as contrasted with the medical aspect. At greater length he discusses the nature of corporations, distinguishing clearly between public and private ones. A further distinction is drawn between eleemosynary hospitals and others.

A hospital must be conducted with reasonable skill, care and diligence, and its patients are entitled to competent medical advice and treatment. The purely charitable institution, however, is not liable for the negligence of its servants, provided due care is exercised in their selection. No uniform decision has been reached as to whether the hospital is answerable for injury to others than patients.

The maximum care must be exercised in the systematic keeping of records inasmuch as they may become of great legal importance. This point is well emphasized by a few illustrations. The records are immune from disclosure except in states where the common law be

modified by statute; under the common law, disclosures to a physician are not protected. In casualty cases, an interested party may have the record introduced into court by legal process.

The law governing the holding of post-mortem examinations is made very clear, but there is no discussion in regard to obtaining consent for operations nor as to what the duty of the physician is when unexpected conditions are discovered during an operation. No man may be restrained of his liberty illegally; even his signing an agreement to remain does not justify the officials in detaining him. On the other hand, a hospital may be remiss in discharging a patient prematurely, although the institution is not liable for error in judgment. The statutory qualifications for holding a state hospital office are reviewed. There is a timely warning against any unneutral attitude on the part of officials and attendants toward legal matters of a patient.

Hospitals are usually incorporated and subject to visitation by state authorities, some person or board designated by the founder, or by the founder himself and his heirs. The right to establish a hospital cannot be prohibited nor can oppressive and unreasonable regulations be imposed. Hospitals for contagious diseases may be established by public health departments when necessary.

The liability of relatives, employers and others for the support of patients is briefly outlined. The book closes with the presentation in full of two chapters of the Geneva Convention of 1906, relative to naval and military hospitals.

The legal principles involved are sound; but there is considerable repetition and use of long, though interesting, statements of fact, quoted testimony and decisions. The exemption from liability of the managers of charitable hospitals for the misfeasances and nonfeasances of the employes is ably discussed, and the rule that they are liable only for negligence in the choosing of the employes, a point which has not been so well settled in England as in this country, is clearly stated and well illustrated. But just how far the members of the staff come under the title of employes is not discussed. The degree of care legally required of a nurse, which does not mean the highest possible degree, but what a well-trained nurse would do under the cirumstances, follows the general principles of law relating to negligence.

The ruling of the California courts in declaring that the licensing provision in that state constituted an arbitrary exercise of the police power is very unfortunate, and is a good example of a situation which so frequently arises in the United States, that is, a court's declaring that the legislative body erred in the determination of a fact, and substituting its own determination for that of the legislature.

The chapter on Remuneration and Support fails to touch upon many important points. The questions of how far negligence or failure to

effect a cure bars a claim for fees and whether recovery should be had for the performance of operations and rendering of services the usefulness of which is doubtful, as well as many other similar questions relating to remuneration, might well have been included here.

It may be confidently stated that any one connected with a hospital, in an official or advisory capacity, unless he is already versed in matters covered by this book, will be well repaid for reading it.

SAMUEL W. HAMILTON,
ROY HABER.

BOOKS RECEIVED

Ash, Isaac Emery. Fatigue and its effect upon control. New York: The Science Press, 1914. (Archives of Psychology, edited by R. S. Woodworth, no. 31, June, 1914.)

Carroll, Robert S. The mastery of nervousness—based upon self re-education. New York: The Macmillan Company, 1917.

Humphrey, Seth K. Mankind—racial values and the racial prospect. New York: Charles Scribner's Sons, 1917.

Mayo, Marion J. The mental capacity of the American negro. New York: The Science Press, 1913. (Archives of Psychology, edited by R. S. Woodworth, no. 28, November, 1913.)

Young, Meredith. The mentally defective child. New York: Paul B. Hoeber, 1916.

CURRENT BIBLIOGRAPHY*

MARCH–OCTOBER, 1917

Compiled by

MABEL W. BROWN, A.B.
Librarian, The National Committee for Mental Hygiene

Adams, J. Barfield. Zola's studies in mental disease. J. of ment. science (Lond.), v. 63, p. 165–99, April 1917.

Adler, Alfred, M. D. Study of organ inferiority and its psychical compensation; a contribution to clinical medicine; tr. by S. E. Jelliffe. N. Y.: Nerv. and ment. dis. pub. co., 1917. 86 p.

Adler, Herman M., M. D. Broader psychiatry and the war. Mental hygiene, v. 1, p. 364–70, July 1917.

Adler, Herman M., M. D. Organization of psychopathic work in the criminal courts. J. of crim. law and criminology, v. 8, p. 362–74, Sept. 1917.

Adler, Herman M., M. D. Psychiatric contribution to the study of delinquency. J. of crim. law and criminology, v. 8, p. 45–68, May 1917.

American public health association—Committee on venereal diseases. Progress report. Amer. j. of pub. health, v. 7, p. 414–15, April 1917.

Anderson, Cyrus H., M. D. Some forms of insanity most frequently met by physicians. Ill. med. j., v. 31, p. 178, March 1917.

Anderson, Victor V., M. D. Comparative study of feeblemindedness among offenders in court. J. of crim. law and criminology, v. 8, p. 428–34, Sept. 1917.

Anderson, Victor V., M. D. Drug users in court. J. of crim. law and criminology, v. 7, p. 903–06, March 1917. Also Bost. med. and surg. j., v. 176, p. 755–57, May 31, 1917.

Anderson, Victor V., M. D. Feeblemindedness as seen in court. Bost. med. and surg. j., v. 176, p. 429–31, March 22, 1917. Also Mental hygiene, v. 1, p. 260–65, April 1917.

Armstrong-Jones, Robert, M. D. Dreams and their interpretation. Amer. j. of insanity, v. 73, p. 655–72, April 1917. Also Practitioner (Lond.), v. 89, p. 201, March 1917. Also J. of ment. science (Lond.), v. 63, p. 200–25, April 1917.

Auer, Murray, M. D. Some of the nervous and mental conditions arising in the present war. Mental hygiene, v. 1, p. 383–88, July 1917.

Bahr, Maxwell A., M. D. Cases demonstrating some factors in the early diagnosis of insanity. West. med. times, v. 36, p. 359–64, March 1917.

Bailey, Carolyn S. Curing tomorrow's criminals. Forum, v. 57, p. 349–57, March 1917.

Bailey, Pearce, M. D. Care of disabled returned soldiers. Mental hygiene, v. 1, p. 345–53, July 1917.

Bailey, Pearce, M. D. Efficiency and inefficiency; a problem in medicine. Reprint from Mental hygiene, v. 1, p. 196–210, April 1917.

Bailey, Pearce, M. D. Expert medical testimony in criminal cases. N. Y. state med. j., v. 17, p. 161–66, April 1917.

Bailey, Pearce, M. D. Psychiatric clinics. New republic, v. 11, p. 131–33, June 2, 1917.

Bailey, Pearce, M. D. Psychiatry and the army. Harper's monthly mag., v. 135, p. 251–57, July 1917.

Ballard, E. F., M. D. Epitome of mental diseases. Lond.: Churchill, 1917.

Barnes, Francis M., M. D. Value of early treatment of mental disorders. Reprint from J. of Mo. state med. assoc., v. 14, p. 108, March 1917.

Barlow, Charles A., M. D. Care of the insane and Spencer state hospital. Spencer, W. Va., 1917. 37 p. illus.

Barrett, Albert M., M. D. The state psychopathic hospital. Ia. bull. of state institutions, v. 19, p. 63–79, Jan. 1917.

Beers, Clifford W. Mind that found itself. 4th ed. N. Y.: Longmans, 1917. 407+41 p.

Beman, Lamar T., comp. Selected articles on prohibition of the liquor traffic. 2d rev. ed. White Plains: Wilson, 1917. 237 p. (Debaters' handbook series.)

Bernstein, Charles, M. D. State care of the feebleminded in New York. J. of sociologic med., v. 18, p. 201–10, June 1917.

Bill relating to defective children. J. of Ia. state med. soc., v. 7, p. 81–82, Feb. 15, 1917.

Bingham, Anne T., M. D. Practical application of the results of intensive study of delinquents. J. of crim. law and criminology, v. 7, p. 867–76, March 1917.

Bird, Charles. From home to the charge; a psychological study of the soldier. Reprint from Amer. j. of psychology, v. 28, p. 315–48, July 1917.

*This bibliography is uncritical and does not include articles of a purely technical or clinical value.

Bisch, Louis E., M. D. Diagnostic methods in determining feeblemindedness. Dental cosmos, v. 59, p. 496–500, May 1917.

Blake, Mabelle E. Defective girl who is immoral. Bost. med. and surg. j., v. 177, p. 492–94, Oct. 4, 1917.

Bloomingdale hospital. Physical education in men's and women's departments. White Plains: 1917. 11 p.

Body and mind; those who are mentally defective are likely to be physically below par as well. J. of heredity, v. 8, p. 286–87, June 1917.

Bowen, A. L. Charitable institutions of Illinois. Minn. . . . institutions quar., v. 16, p. 63–75, Feb. 1917.

Bowers, Paul E., M. D. Crime and disease as seen by the prison physician. Ill. institution quar., v. 8, p. 176–78, March 31, 1917.

Bowers, Paul E., M. D. Necessity for medical examination of prisoners at the time of trial. J. of sociologic med., v. 18, p. 222–33, June 1917.

Bowers, Paul E., M. D. Work in the treatment of insane criminals. Mod. hosp., v. 8, p. 406–07, June 1917. Illus.

Bowler, Alida C. Picture arrangement test. Psychological clin., v. 11, p. 37–54, April 15, 1917.

Bowler, Alida C. Study of seventy-five delinquent girls. J. of delinquency, v. 2, p. 156–68, May 1917.

Briggs, Lloyd V., M. D. Study of the problem of the so-called defective delinquent and what has been done in Massachusetts. Bost. med. and surg. j., v. 671, p. 371–80, March 15, 1917.

Brigham, C. C. Two studies in mental tests. . . . Princeton: Psych. rev. co., 1917. 254 p.

British national council for combating venereal diseases. Report of a meeting at the Mansion House, London. Social hygiene, v. 3, p. 229–35, April 1917.

A broader conception of feebleminded-ness. Editorial in N. Y. med. j., v. 105, p. 799–800, April 28, 1917.

Bronner, Augusta F. Psychology of special abilities and disabilities. Bost.: Little, 1917. 269 p.

Brown, D. Lucille F. Testing epileptics. Training school bull., v. 14, p. 12–16, March 1917.

Brown, Mabel W., and Williams, Frankwood E., M. D. Neuro-psychiatry and the war; a bibliography with abstracts. Mental hygiene, v. 1, p. 409–74, July 1917.

Bryan, W. A., M. D. Re-educational treatment of the insane. Ia. bull. of state institutions, v. 19, p. 91–97, Jan. 1917.

Burr, Albert H., M. D. Alcoholism; its psychology and its rational cure by psychotherapy. Ill. med. j., v. 31, p. 245, April 1917.

Burrow, Trigant, M. D. Meaning of psychoanalysis. J. of abnormal psychology, v. 12, p. 58–68, April–May, 1917.

Caldwell, C. B., M. D. Illinois' commitment law for feebleminded. Ill. institution quar., v. 8, p. 69–71, March 31, 1917.

California—Committee on mental deficiency and the proposed institution for the care of feebleminded and epileptic persons, 1915. Report . . . transmitted to the Legislature, Jan. 1917. Whittier: Whittier state school, 1917. 16 p.

Campbell, C. Macfie, M.D. Educational methods and the fundamental causes of dependency. Mental hygiene, v. 1, p. 235–40, April 1917.

Carmichael, Francis A., M. D. Possible rôle of glands with internal secretions in problems of psychiatry. J. of Kan. med. soc., v. 17, p. 98, April 1917.

Carr, H. Nature of mental process. Psychological rev., v. 24, p. 181–87, 1917.

Carstens, C. C. What it means to have non-committed feebleminded in the community. Bost. med. and surg. j., v. 177, p. 487–89, Oct. 4, 1917.

Claiborne, J. Herbert, M. D. Stuttering relieved by reversal of manual dexterity, with remarks on the subject of symbol amblyopia. N. Y. med. j., v. 105, p. 577–81, March 31, 1917.

Clark, Fred P., M. D. Beneficial effects of work therapy for the insane. Mod. hosp., v. 8, p. 392–93, June 1917.

Clark, L. Pierce, M. D. Psychopathic children; what New York City is doing for them. Ungraded, v. 2, p. 155–61, 179–90, April–May 1917. Reprinted from the N. Y. med. j., v. 99, p. 709–20, April 1914.

Clarkson, R. D., M. D. Care of mentally defective children. Edin. med. j., new series, v. 18, p. 375–82, May 1917.

Cohen, M. H. Distinction between the mental and the physical. J. of philosophy and psychology, v. 14, p. 261–67, 1917.

Colonization of social misfits in New York State. Mod. hosp., v. 8, p. 28–29, July 1917. Illus.

Columbia university—Teachers college—School of practical arts. Courses for teachers of occupation therapy, beginning Oct. 9, 1917. Leaflet.

Copp, Owen, M. D. Friends of the insane—Dr. Thomas Story Kirkbride. Psychogram, v. 1, no. 10, p. 10–11, April 1917.

Coriat, Isador H., M. D. Abnormal sensations (our senses and what they mean to us). N. Y.: Moffat, 1917.

Coriat, Isador H., M. D. Some statistical results of the psychoanalytic treatment of the psychoneuroses. Psychoanalytic rev., v. 4, p. 209–16, April 1917.

Coriat, Isador H., M. D. What is psychoanalysis? N. Y.: Moffat, 1917. 127 p.

Crafts, L. W. Bibliography of feeblemindedness in its social aspects. J. of

psycho-asthenics. Monograph sup. 1-3, March 1917. 73 p.

Crafts, L. W., and Doll, E. A. Proportion of mental defectives among juvenile delinquents. J. of delinquency, v. 2, p. 119-43, 191-208, May and July 1917.

Craig, Maurice, M. D. Psychological medicine; a manual on mental diseases for practitioners and students. 3d ed. Lond: Churchill, 1917. 484 p.

Crothers, Thomas D., M. D. Outlines of new work concerning the alcoholic problem. Med. rec., v. 92, p. 418-19, Sept. 8, 1917.

Crusade against venereal disease. Editorial in N. Y. med. j., v. 105, p. 846-47, May 5, 1917.

Custodial care of the feebleminded. Editorial in Amer. med., new series, v. 12, p. 150-51, March 1917.

Dalton, Charles F., M. D. Alcohol from a medical standpoint. Bull. of Vt. state bd. of health, v. 17, no. 3, p. 9-15, March 1, 1917.

Dawes, Spencer L., M. D. New immigration law; an analysis of the changes which relate to the mentally defective. S. C. A. A. news, v. 5, no. 8, p. 10-11, May 1917.

Dawson, William J. G., M. D. Sonoma state home for feebleminded and epileptics. Mod. hosp., v. 8, p. 14, July 1917.

Dean, M. M., M. D. Responsibility of the general practitioner. Training school bull., v. 14, p. 74-80, Sept. 1917.

Delage, Yves. Psychoanalysis, a new psychosis; tr. by T. Drapes in J. of ment. science (Lond.), v. 63, p. 61-76, Jan. 1917.

Densten, J. C., M. D. Drug addiction and the Harrison antinarcotic law. N. Y. med. j., v. 105, p. 747-48, April 21, 1917.

Dercum, Francis X., M. D. Relative infrequency of the drug habit among the middle and upper classes; treatment and final results. Reprint from Penn. med. j., v. 20, p. 362, March 1917.

Dercum, Francis X., M. D. Rest, suggestion, and other therapeutic measures in nervous and mental diseases. 2d ed. Phil.: Blakiston, 1917. 395 p.

Diller, Theodore, M. D. Commitment of the insane in the state of Pennsylvania. Penn. med. j., v. 20, p. 778, Aug. 1917.

Diller, Theodore, M. D. The psychoneuroses; how shall we look on them today? J. of Amer. med. assoc., v. 69, p. 956-58, Sept. 22, 1917.

Doll, Edgar A. Anthropometry and feeblemindedness. Training school bull., v. 14, p. 30-33, April 1917.

Doll, Edgar A. Clinical studies in feeblemindedness. Bost.: Badger, 1917.

Doll, Edgar A. Initial tests and methods of testing. Delinquent, v. 7, p. 7-9, March 1917.

Doll, Edgar A. Mental tests and methods of testing. Training school bull., v. 14, p. 3-6, March 1917.

Donkin, Sir Bryan, M. D. Notes on mental defect in criminals. J. of ment. science (Lond.), v. 63, p. 16-35, Jan. 1917.

Downey, June E. Stanford adult intelligence tests. J. of delinquency, v. 2, p. 144-55, May 1917.

Drug addicts; a public health problem. N. Y. city dept. health, Weekly bull., new series, v. 6, p. 305-07, Sept. 29, 1917.

Dunton, William R., jr., M. D. Examination of patients suspected of being insane. Reprint from Med. rec., v. 92, p. 497-99, Sept. 22, 1917.

Dunton, William R., jr., M. D. History of occupational therapy. Mod. hosp., v. 8, p. 380-82, June 1917.

Dunton, William R., jr., M. D. Training of occupational teachers and directors; Maryland psychiatric bull., v. 7, p. 8-23, July 1917.

East, E. M. Hidden feeblemindedness . . . J. of heredity, v. 8, p. 215-17, May 1917.

East, W. N. Case of psychasthenia with criminal impulses. Lancet (Lond.), March 31, 1917. p. 486.

Ellis, Havelock. Birth-control and eugenics. Eugenics rev., v. 9, p. 32-41, April 1917.

Emerson, Ernest B., M. D. Mental states responsible for malingering. Bost. med. and surg. j., v. 176, p. 737-40, May 24, 1917.

Fantus, Bernard, M. D. Rôle of alcohol in the welfare of the human race from the standpoint of pharmacology and therapeutics. J. of Amer. med. assoc., v. 69, p. 10-12, July 7, 1917.

Farrar, Clarence B., M. D. Problem of mental disease in the Canadian army. Mental hygiene, v. 1, p. 389-91, July 1917.

Farrar, Clarence B., M. D. War and neurosis, with some observations of the Canadian expeditionary force. Amer. j. of insanity, v. 73, p. 693-719, April 1917.

Fernald, Guy G., M. D. Defective delinquent class; differentiating tests. 2d ed. Reprint from Amer. j. of insanity, v. 68, p. 523-92, April 1912.

Fernald, Walter E., M. D. Standardized fields of inquiry for clinical studies of borderline defectives. Reprint from Mental hygiene, v. 1, p. 211-34, April 1917.

Ferri, Enrico. Criminal sociology; tr. by J. I. Kelly. Bost.: Little, 1917. 577 p.

Fisk, Eugene L. Alcohol and human efficiency. Atlan., v. 119, p. 203-10, Feb. 1917.

Fisk, Eugene L. Alcohol and physiology. Atlan., v. 119, p. 43-50, Jan. 1917.

Fisk, Eugene L. Alcohol; its relation to human efficiency and longevity. N. Y.: Funk, 1917. 216 p.

Fitts, Ada M. Function of special classes for mentally defective children in the public schools. Ungraded, v. 2, p. 203–06, June 1917.

Frink, H. W., M. D. Some analyses in the psychopathology of everyday life. J. of abnormal psychology, v. 12, p. 25–33, April–May, 1917.

Fry, Frank R., M. D. The neurasthenic at the threshold. J. of Amer. med. assoc., v. 69, p. 955–56, Sept. 22, 1917.

Furbush, Edith M. Mental disease, suicides and homicides in the United States army and navy, 1897–1915; tables prepared from the Annual reports of the Surgeons general. Mental hygiene, v. 1, p. 406–08, July 1917.

Garrison, Charlotte G., Burke, Agnes, and Hollingsworth, Leta S. Psychology of a prodigious child. J. of applied psychology, v. 1, p. 101–10, 1917.

Gesell, Arnold L., M. D. Public school and the study of delinquency. Editorial in J. of delinquency, v. 2, p. 92–93, March 1917.

Gilliland, A. R. Mental ability of 100 inmates of the Columbus, Ohio, workhouse. J. of crim. law and criminology, v. 7, p. 857–66, March 1917.

Glueck, Bernard, M. D. Place of a psychiatric clinic in a prison system. N. Y. med. j., v. 105, p. 748–49, April 21, 1917.

Glueck, Bernard, M. D. Types of delinquent careers. Reprint from Mental hygiene, v. 1, p. 171–95, April 1917.

Goddard, Henry H. Eugenics from a professional standpoint. Reprint from J. of N. J. med. soc., v. 14, p. 62, Feb. 1917.

Goddard, Henry H. Mental tests and the immigrant. J. of delinquency, v. 2, p. 243–77, Sept. 1917. References.

Gordon, Alfred, M. D. Race betterment based upon principles of physical and mental prophylaxis. N. Y. med. j., v. 106, p. 153–56, July 28, 1917.

Green, E. M., M. D. Classification of mental disorders adopted by the Georgia state sanitarium. J. of Ga. med. assoc., v. 7, p. 41, July 1917.

Green, E. M., M. D. Manic-depressive psychosis in the negro. Amer. j. of insanity, v. 73, p. 619–26, April 1917.

Gregory, Menas S., M. D. Modern conception of inebriety. N. Y. med. j., v. 105, p. 625–29, April 7, 1917.

Groves, Ernest R. Sociology and psychoanalytic psychology; an interpretation of the Freudian hypothesis. J. of sociology, v. 23, no. 1, July 1917.

Gulick, Walter V., M. D. Social concept of psychosis. Northwest med., v. 16, p. 116, April 1917.

Haberman, J. Victor, M. D. Shiftling, charlatan and vagabond. Bost. med. and surg. j., v. 176, p. 757–59, May 31, 1917.

Haines, Thomas H., M. D. Delinquent dullards. Editorial in J. of delinquency, v. 2, p. 288–90, Sept. 1917.

Haines, Thomas H., M. D. Notes on mental conditions of adult female offenders in Ohio. J. of delinquency, v. 2, p. 53–58, March 1917.

Haines, Thomas H., M. D. Subsidizing mental deficiency; the "Pauper Idiot Act" of Kentucky. Mental hygiene, v. 1, p. 274–78, April 1917.

Hall, G. Stanley. Psychology and the war. J. of heredity, v. 8, p. 442–47, Oct. 1917.

Hall, Herbert J., M. D. Remunerative occupations for the handicapped. Mod. hosp., v. 8, p. 383–86, June 1917. Illus.

Hamill, R. C. Some considerations of the problems of psychiatry. Med. clin., v. 2, p. 707–19, 1917.

Harris, R. O. Probation in its relation to social welfare. J. of crim. law and criminology, v. 7, p. 810–16, March 1917.

Hastings, Charles John, M. D. Public health aspects of venereal diseases. Toronto pub. health j., v. 8, p. 37, Feb. 1917.

Hastings, George A. What New York state is doing to meet the mentally sick half-way. Ungraded, v. 2, p. 191–96, May 1917.

Hauck, A. A. Report of sensory and mental tests at the Idaho industrial training school. St. Anthony: 1917.

Health news; venereal disease number. N. Y. state dept. of health. Monthly bull., new series, v. 12, p. 111–30, May 1917.

Healy, William. Mental conflicts and misconduct. Bost.: Little, 1917. 330 p.

Hickman, H. B. "The defective delinquent." Training school bull., v. 14, p. 9–11, March 1917.

Hill, Robert W., M. D. Influence of defect and venereal diseases upon the public welfare. Alb. med. ann., v. 38, p. 401–17, Sept. 1917.

Hotchkis, R. D. Renfrew district asylum as a war hospital for mental invalids . . . J. of ment. science (Lond.), v. 63, p. 238–49, April 1917.

Hulbert, Harold S., M. D. Medieval care of the insane in modern times; "The county care system." J. of Mich. state med. soc., v. 16, p. 401–06, Sept. 1917.

Hunter, Joel D. Mothers' pensions as a preventive of juvenile truancy and delinquency. Editorial in J. of crim. law and criminology, v. 7, p. 802–03, March 1917.

Hutchings, Richard H., M. D. The state and the insane. J. of sociologic med., v. 18, p. 211–21, June 1917.

Hyde, Arthur G., M. D. Relation of syphilis to mental disease. Cleveland med. j., v. 16, p. 163, March 1917.

Importance of certain factors in the performance of mental tests. Editorial in Med. rec., v. 91, p. 596–97, April 7, 1917.

In Pennsylvania. Editorial in Mental hygiene, v. 1, p. 161–63, April 1917.

Ishida, Naboru. History of the care and treatment of the insane in Japan (Letter). Amer. j. of insanity, v. 73, p. 743–44, April 1917.

Jarrett, Mary C. The psychopathic employee; a problem of industry. Med. and surg., v. 1, p. 727–41, Sept. 1917.

Jelliffe, Smith Ely, M. D. Mentality of the alcoholic. N. Y. med. j., v. 105, p. 629–35, April 7, 1917. References.

Jelliffe, Smith Ely, M. D. Psychotherapy and the drama; the therapeutic message of "Peter Ibbetson." N. Y. med. j., v. 106, p. 442–47, Sept. 8, 1917.

Jelliffe, Smith Ely, M. D. "The Yellow Jacket" and the flowery kingdom; a recent dramatic conception of the "Oedipus complex." Med. rec., v. 91, p. 664–66, April 21, 1917.

Johnson, Glenn R. Unemployment and feeblemindedness. J. of delinquency, v. 2, p. 59–73, March 1917.

Karpas, Morris J., M. D. Psychopathology of prostitution. N. Y. med. j., v. 106, p. 103–07, July 21, 1917. References.

Kellor, Eleanor L., M. D. Preliminary report of the effect of baths on retarded children. Amer. physical educ. rev., v. 22, p. 74–76, Feb. 1917.

Kelso, Robert W. Feeblemindedness as an element in poverty. Bost. med. and surg. j., v. 177, p. 484–87, Oct. 4, 1917.

Kemble, W. F. Choosing employees by mental and physical tests. N. Y.: Engineering mag. co., 1917.

A larger view of mental hygiene work. Editorial in Mental hygiene, v. 1, p. 157–58, April 1917.

Lay, Wilfrid. Man's unconscious conflict. N. Y.: Dodd, 1917. 318 p.

Lorand, Arnold. Building human intelligence, tr. by P. Fischelis. Chic. bk. co., 1917. 451 p.

MacDonald, John B., M. D. Community value of the out-patient department of the hospital for the insane. Reprint from Mental hygiene, v. 1, p. 266–73, April 1917.

Mateer, Florence. Some criteria for the evaluation of mental tests and test series. Mental hygiene, v. 1, p. 241–51, April 1917.

Matthews, A. C., M. D. Treatment of drug and alcoholic addictions. Calif. state j. of med., v. 15, p. 366–70, Sept. 1917.

Mayer, Edward E., M. D. Traumatic neuroses, with special reference to their medicolegal relations. J. of Amer. med. assoc., v. 69, p. 958–64, Sept. 22, 1917.

Meagher, John F. W., M. D. Personal service to the insane. Reprint from N. Y. med. j., v. 105, p. 1248–51, June 30, 1917.

Melville, Norbert J. Standard method of testing juvenile delinquency by the Binet-Simon scale. . . . Phil.: Lippincott, 1917. 140 p.

Meyer, Adolf, M. D. Progress in teaching psychiatry. J. of Amer. med. assoc., v. 69, p. 861–63, Sept. 15, 1917.

Mosher, J. Montgomery, M. D. The mental nurse. Alb. med. ann., v. 38, p. 461–70, Oct. 1917.

Mullan, E. H., M. D. Mental examination of immigrants; administration and line inspection at Ellis Island. U. S. pub. health repts., v. 32, p. 733–46, May 18, 1917.

Murdoch, J. M., M. D. State care for the feebleminded. Mod. hosp., v. 8, p. 12–13, July 1917.

New Jersey colonies for the feebleminded. Mod. hosp., v. 9, p. 30–31, July 1917. Illus.

New York committee on feeblemindedness. Facts about the feebleminded. N. Y.: 1917. Pamphlet.

New York committee on feeblemindedness. Needs of the department of ungraded classes. N. Y.: 1917. 12 p.

New York state charities aid association. S. C. A. A. news; feebleminded number. 12 p. illus. S. C. A. A. news, v. 5, no. 6, March 1917.

New York state charities aid association and New York committee on feeblemindedness. The number of feebleminded in New York State. N. Y.: 1917. 16 p.

Neymann, Clarence A., M. D. Some experiences in the German Red Cross. Mental hygiene, v. 1, p. 392–96, July 1917.

Page, Charles W., M. D. Friends of the insane; Dorothea Lynde Dix. Psychogram, v. 1, no. 11, p. 12–14, May 1917.

Paton, Stewart, M. D. Mobilizing the brains of the nation. Reprint from Mental hygiene, v. 1, p. 334–44, July 1917.

Payne, Emma L. Special classes in Vincennes, Indiana. Training school bull., v. 14, p. 18–20, March 1917.

Pearson, Charles B., M. D. Study of the relation of volition to the management of drug and alcoholic addictions. Med. rec., v. 91, p. 589–91, April 7, 1917.

Pintner, Rudolf, and Toops, Herbert A. Chart for rapid computation of point scale scores. J. of delinquency, v. 2, p. 209–210, July 1917.

Pintner, Rudolf, and Toops, Herbert A. Mental survey of the population of a workhouse. J. of delinquency, v. 2, p. 278–87, Sept. 1917.

Pintner, Rudolf. Mental survey of the school population of a village. School and society, v. 5, p. 497–600, May 19, 1917.

Pollock, Horatio M. Decline of alcohol as a cause of insanity. Psychiatric bull., v. 2, p. 103–08, April 1917.

Porteus, S. D. Mental tests with delinquents and Australian aboriginal children. Psychological rev., v. 24, p. 32–42, 1917.

Pressey, S. L. Distinctive features in psychological test measurements made upon dementia praecox and chronic alco-

holic patients. J. of abnormal psychology, v. 12, p. 130–39, June 1917.

Prevention and cure of venereal diseases. Editorial in Amer. j. of pub. health, v. 7, p. 378–79, April 1917.

Progressive insight into the problem of drug addiction. Editorial in N. Y. med. j., v. 105, p. 511, March 17, 1917.

Psychiatry in war. Editorial in Mental hygiene, v. 1, p. 165–67, April 1917.

Punnett, R. C. Eliminating feeblemindedness. J. of heredity, v. 8, p. 464–66, Oct. 1917.

Putnam, James J., M. D. Sketch for a study of New England character. J. of abnormal psychology, v. 12, p. 78–99, June 1917.

Ravenel, Mazÿck P., M. D. Prophylaxis of venereal diseases. Social hygiene, v. 3, p. 185–95, April 1917.

Redfield, Casper L. Origin of mental power. J. of ment. science (Lond.), v. 63, p. 56–61, Jan. 1917.

Relationship between mental and muscular work. Editorial in Med. rec., v. 91, p. 244, Feb. 10, 1917.

Richmond, M. E. Social diagnosis. N. Y.: Russell Sage found., 1917. 511 p.

Rosanoff, Aaron J., M. D. Survey of mental disorders in Nassau County, N. Y., July–Oct. 1916. N. Y.: Natl. Comm. for Mental Hygiene, 1917. Publication no. 9.

Rossy, C. S. The feebleminded in industry. Mod. hosp., v. 9, p. 204–06, Sept. 1917.

Ruggles, A. H., M. D. Occupation therapy in the mental hospital. Mod. hosp., v. 8, p. 404–05, June 1917.

Salmon, Thomas W., M. D. Some new fields in neurology and psychiatry. J. of nerv. and ment. dis., v. 46, p. 90–99, July 1917.

Salmon, Thomas W., M. D. Use of institutions for the insane as military hospitals. Mental hygiene, v. 1, p. 354–63, July 1917.

Sandy, William C., M. D. Care and treatment of the insane in the county institutions of Pennsylvania. Mental hygiene, v. 1, p. 279–90, April 1917.

Sandy, William C., M. D. Psychiatric aspects of pellagra. Amer. j. of insanity, v. 73, p. 609–17, April 1917.

Sandy, William C., M. D. Psychiatry and the general practitioner. J. of S. C. med. assoc., v. 13, p. 540, May 1917.

Schier, Anton R., M. D. Further study of mental tests in the examination of recruits. Reprint from U. S. naval med. bull., v. 11, no. 3, 1917.

Sessions, Mina A. Feebleminded in Ohio. J. of heredity, v. 8, p. 291–98, July 1917. Illus.

Shanahan, William T., M. D. Epilepsy. Crouse-Irving bull., v. 4, p. 106–10, Sept. 1917.

Shanahan, William T., M. D. Institutional care of epileptics. Mod. hosp., v. 9, p. 10–11, July 1917. Illus.

Shaw, A. L., M. D. Therapeutic value of amusements to the epileptic. Craig colony med. bull., April 1917, p. 39–47.

Sickels, Lucy M. What is being done for the afterlife of the delinquent girl? In. bull. of state institutions, v. 19, p. 142–51, April 1917.

Singer, H. Douglas, M. D. Modern hospital for the insane from the standpoint of medical service; research and educational work. Ill. institution quar., v. 8, p. 92–97, March 31, 1917. Also in Ill. med. j., v. 31, p. 344, May 1917.

Singer, H. Douglas, M. D. Suggestions for a scheme of graphic representation of personality and psychosis. J. of abnormal psychology, v. 12, p. 114–29, June 1917.

Smith, A. D. Intelligence tests in children. Long Island med. j., v. 11, p. 215–18, 1917.

Some medical features of the new immigration law. Editorial in Mental hygiene, v. 1, p. 163–65, April 1917.

Somerville, Henry. Eugenics and the feebleminded. Cath. world, v. 105, p. 209–18, May 1917.

Southard, Elmer E., M. D. Effects of high explosives upon the central nervous system; a review of Mott's Lettsomian lectures, 1916, and G. Elliot Smith's "Shell-shock and its lessons." Mental hygiene, v. 1, p. 397–405, July 1917.

Starch, Daniel. Similarity of brothers and sisters in mental traits. Psychological rev., v. 24, p. 235–38, 1917.

Stearns, A. Warren, M. D. Defectives in our prisons. Bost. med. and surg. j., v. 176, p. 801–03, June 7, 1917.

Stearns, A. Warren, M. D. Social problems of the feebleminded. J. of Ark. med. soc., v. 13, p. 249–50, May 1917.

Stedman, Henry R., M. D. Recent progress in psychiatry. Bost. med. and surg. j., v. 176, p. 574–77, April 19, 1917.

Strecker, Edward A., M. D. Continuous bath in mental disease. J. of Amer. med. assoc., v. 68, p. 1796–99, June 16, 1917.

Strong, E. K., jr. The learning curve as a diagnostic measure of intelligence. Psychological bull., v. 14, p. 153, 1917.

Studley, F C., M. D. The social misfit; a study of Miss X. Interstate med. j., v. 24, p. 819–30, Sept. 1917.

Sturgis, Annis M. Possibilities of outlining work for subnormal children along the line of productive labor. Ungraded, v. 2, p. 162–66, April 1917.

Supervision of the feebleminded. Editorial in Mental hygiene, v. 1, p. 168–70, April 1917.

Taft, Jessie. Mental pitfalls in industry and how to avoid them. Med. and surg., v. 1, p. 679–85, Sept. 1917.

Terhune, William B., M. D. Colonization of epileptics. Reprint from New Orleans med. and surg. j., v. 69, no. 9, March 1917.

Terman, Lewis M. Intelligence quotient of Francis Galton. Reprint from Amer. j. of psychology, v. 28, April 1917.

Terman, Lewis M. Trial of mental and pathological tests for an examination for policemen and firemen. Reprint from J. of applied psychology, v. 1, p. 17–29, March 1917.

Thacher, George A. Feeblemindedness and crime in Oregon. J. of delinquency, v. 2, p. 211–24, July 1917.

Thomson, Elnora E. Occupation and its realtion to mental hygiene. Mod. hosp., v. 8, p. 397–98, June 1917.

Tilney, Frederick, M. D. Opportunities in neurology. J. of nerv. and ment. dis., v. 46, p. 81–89, July 1917.

To prevent procreation of certain classes in Oregon: House bill 162. J. of crim. law and criminology, v. 7, p. 910–12, March 1917.

Tullidge, E. Kilbourne, M. D. War and venereal diseases. Med. rec., v. 92, p. 505–07, Sept. 22, 1917.

Wagner, Charles G., M. D. Reception, examination and care of new admissions. Amer. j. of insanity, v. 73, p. 673–79, April 1917.

Walhay, Charlotte M. Introduction of willow basketry. Training school bull., v. 14, p. 16–17, March 1917.

Wallace, Robertson. How to avoid nervous disorders. N. Y.: Britton, 1917. 175 p.

Wallin, J. E. Wallace. Feebleminded in the state of Missouri. Psychological clin., v. 11, p. 55–62, April 15, 1917.

Wallin, J. E. Wallace. Individual tests in the Binet-Simon scale. Psychological clin., v. 11, p. 79–85, May 1917.

Wansboro, William J., M. D. Feeblemindedness, technical and legal. Alb. med. ann., v. 38, p. 164–72, April 1917.

Wells, Frederic L. Alternative methods for mental examiners. J. of applied psychology, v. 1, p. 134–43, 1917.

Wells, Frederic L. Mental adjustments. N. Y.: Appleton, 1917. 331 p.

White, V. H. Mental control of the body; or, Health through self-conquest. N. Y.: Clode, 1917.

White, William A., M. D. Psychanalysis and the practice of medicine. J. of Amer. med. assoc., v. 68, p. 1591–96, June 2, 1917.

White, William A., M. D. Psychoanalytic tendencies. Amer. j. of insanity, v. 73, p. 599–607, April 1917.

White, William A., M. D. State hospital and the war. Mental hygiene, v. 1, p. 375–82, July 1917.

Williams, Frankwood E., M. D. Dr. Samuel G. Howe and the beginning of work for the feebleminded in Massachusetts. Bost. med. and surg. j., v. 177, p. 481–84, Oct. 4, 1917.

Williams, J. Harold. Delinquency and density of population. J. of delinquency, v. 2, p. 74–91, March 1917. References.

Williams, J. Harold. Heredity and juvenile delinquency. Eugenics rev., v. 9, p. 18–31, April 1917.

Witmer, Lightner. Diagnostic education; an education for the fortunate few. Psychological clin., v. 11, p. 69–78, May 1917.

Wolbarst, Abraham L., M. D. Plan for the prevention of venereal disease in our military forces. Med. rec., v. 91, p. 725–27, April 28, 1917.

Woodrow, Herbert. Practice and transference in normal and feebleminded children. Reprint from J. of educational psychology, March 1917.

Wright, Harold W., M. D. Some modern phases of psychology; their relation to the training of children and the prevention of "nervousness." Med. rec., v. 91, p. 584–87, April 7, 1917.

Yale, Caroline A. Plea for the instruction and after-school care of the feebleminded deaf. Bost. med. and surg. j., v. 177, p. 490–92, Oct. 4, 1917.

Yawger, Nathaniel S., M. D. The criminal epileptic with consideration of epilepsy as a medicolegal problem. Penn. med. j., v. 20, p. 332, March 1917.

A year in prison for judge and prosecutor. Editorial in Mental hygiene, v. 1, p. 160–61, April 1917.

Yerkes, Robert M. The Binet versus the point scale method of measuring intelligence. J. of applied psychology, v. 1, p. 111–22, 1917.

Yerkes, Robert M. How may we discover the children who need special care? Reprint from Mental hygiene, v. 1, p. 252–59, April 1917.

Yerkes, Robert M. New method of studying ideational and allied behavior in man and other animals. Scientific Amer. sup., v. 83, p. 114–15, Feb. 24, 1917.

Yerkes, Robert M., and Rossy, C. S. Point scale for measurement of intelligence in adolescent and adult individuals. Bost. med. and surg. j., v. 176, p. 564, April 19, 1917.

Yerkes, Robert M. Relation of psychology to military activities. Mental hygiene, v. 1, 371–76, July 1917.

Young, W. W., M. D. Plea for fuller recognition of importance of psychical disorders in medical practice. J. of Ga. med. assoc., v. 6, p. 204, Feb. 1917. Also reprint from Med. council, Jan. 1917.

DIRECTORY OF SOCIETIES AND COMMITTEES FOR MENTAL HYGIENE

(Listed in the order of their origin)

THE CONNECTICUT SOCIETY FOR MENTAL HYGIENE
(Organized, May, 1908)
39 Church Street, New Haven, Conn.
Miss V. M. Macdonald, *Secretary*
Miss Inez Newman, *Associate Secretary*

THE NATIONAL COMMITTEE FOR MENTAL HYGIENE, INC.
(Organized, February, 1909)
50 Union Square, New York City
Dr. Thomas W. Salmon, *Medical Director*
Dr. Frankwood E. Williams, *Associate Medical Director*
Clifford W. Beers, *Secretary*

THE ILLINOIS SOCIETY FOR MENTAL HYGIENE
(Organized, July, 1909)
157 East Ohio Street, Chicago, Ill.
Miss Elnora E. Thomson, *Superintendent*
Mrs. Eleanor C. Slagle, *Director of Occupations*

COMMITTEE ON MENTAL HYGIENE OF THE NEW YORK STATE CHARITIES AID ASSOCIATION
(Organized, May, 1910; an outgrowth of an After-care Committee, organized in 1906)
105 East 22nd Street, New York City
George A. Hastings, *Executive Secretary*
Miss Jessie Taft, *Social Service Director*

THE MASSACHUSETTS SOCIETY FOR MENTAL HYGIENE
(Organized, January, 1913)
15 Ashburton Place, Boston, Mass.
Dr. Charles E. Thompson, *Secretary*

THE MENTAL HYGIENE SOCIETY OF MARYLAND
(Organized, March, 1913; an outgrowth of an After-care Committee, organized in 1911)
401 Garrett Building, Baltimore, Md.
Dr. Charles B. Thompson, *Executive Secretary*

THE COMMITTEE ON MENTAL HYGIENE OF THE PUBLIC CHARITIES ASSOCIATION OF PENNSYLVANIA
(Organized, March, 1913)
Empire Building, Philadelphia, Pa.
Robert D. Dripps, *Executive Secretary*

THE NORTH CAROLINA SOCIETY FOR MENTAL HYGIENE
(Organized, December, 1913)
Dr. Albert Anderson, *Secretary*, Raleigh, N. C.

THE DAYTON MENTAL HYGIENE COMMITTEE
(Organized, March, 1914)
Address: Mrs. J. Franz Dolina, or Mr. A. G. Knebel, Dayton, Ohio

THE SOCIETY FOR MENTAL HYGIENE OF THE DISTRICT OF COLUMBIA
(Organized, April, 1915)
Dr. D. Percy Hickling, *Secretary*
1305 Rhode Island Avenue, Washington, D. C.

THE ALABAMA SOCIETY FOR MENTAL HYGIENE
(Organized, April, 1915)
Dr. W. D. Partlow, *Secretary*, Tuscaloosa, Ala.

THE LOUISIANA SOCIETY FOR MENTAL HYGIENE
(Organized, May, 1915)
Dr. Maud Loeber, *Secretary*
1729 Marengo Street, New Orleans, La.

THE CALIFORNIA SOCIETY FOR MENTAL HYGIENE
(Organized, June, 1915)
Miss Julia George, *Secretary*
638 Phelan Building, San Francisco, Cal.

THE RHODE ISLAND SOCIETY FOR MENTAL HYGIENE
(Organized, March, 1916)
Dr. Frederick J. Farnell, *Secretary*
335 Angell Street, Providence, R. I.

THE OHIO SOCIETY FOR MENTAL HYGIENE
(Organized, May, 1916)
Dr. Thomas H. Haines, *Secretary*
Ninth and Oak Streets, Columbus, Ohio

THE TENNESSEE SOCIETY FOR MENTAL HYGIENE
(Organized, May, 1916)
C. C. Menzler, *Secretary*
Nashville, Tenn.

THE MISSOURI SOCIETY FOR MENTAL HYGIENE
(Organized, May, 1916)
Dr. Francis M. Barnes, Jr., *Secretary*
Humbolt Building, St. Louis, Mo.

THE INDIANA SOCIETY FOR MENTAL HYGIENE
(Organized, October, 1916)
Frank D. Loomis, *Secretary*
88 Baldwin Block, Indianapolis

THE IOWA SOCIETY FOR MENTAL HYGIENE
(Organized, March, 1917)
Dr. Gershom H. Hill
Des Moines, Iowa

THE VIRGINIA SOCIETY FOR MENTAL HYGIENE
(Organized, March, 1917)
Dr. William F. Drewry
Petersburg, Va.